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THE UNIVERSITY OF ALBERTA

HEALTH CARE AND COMMUNITY DEVELOPMENT:
THE INNER CITY OF EDMONTON

by

© DAVID N. McDONALD

A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE
OF MASTER OF ARTS
IN
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DIVISION OF COMMUNITY DEVELOPMENT

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THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled Health Care and Community Development: The Inner City of Edmonton submitted by David N. McDonald in partial fulfilment of the requirements for the degree of Master of Arts in Community Development.

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Date 15 March 78

ABSTRACT

Health and development are closely related concepts. This relationship becomes particularly apparent when one looks at underdeveloped areas. The inner core of the City of Edmonton, specifically Boyle Street and McCauley is one such "underdeveloped area".

The object of this thesis is to investigate (1) the health services of the inner city of Edmonton, (2) their effectiveness, and (3) the role of community development in improving health in that neighbourhood. A variety of research methods was used to achieve this object, including interviewing in the field and an analysis of published data.

The inner city people are described, using demographic variables and a discussion of their lifestyles. The population of fifteen thousand people is heterogeneous. The stereotype that the area is inhabited largely by drunks and "ne'er-do-wells" is false. The majority of the people are stable, well established citizens. It is a minority that constitutes the transient and skid row populations.

The morbidity pattern in the inner city is similar to that of corresponding regions of other North American cities, and is closely related to the demographic and lifestyle characteristics of the people. In particular, disease among the elderly, the children and the skid row groups is a matter of concern. The incidence of some illnesses is higher in the inner city than elsewhere in Edmonton, and the severity of others makes them more apparent.

The City of Edmonton is well supplied with health and social welfare services, but in the study area, medical care is perceived to be either unavailable or inaccessible owing largely to the cultural, psychological and demographic characteristics of the people. This results in lower rates of utilization of the medical resources of the city.

Community development can be used to help people improve their health status. The neighbourhood health centre approach has been effective in other parts of North America and should be applied in Edmonton. The nature of "community" in the inner city makes this form of community development project feasible. Care will have to be taken, however, to ensure that control of the health facility remains in the community's hands and that a high standard of health care is provided.

An outline is given of the steps involved in a community development project which would aim to establish a community health facility in the inner city of Edmonton.

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I wish to express my appreciation to some of the many people who assisted me in the preparation of this thesis.

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Finally I must express my thanks to Mrs. Lory Laing and Dr. Stanley Greenhill of the Department of Community Medicine of the University of Alberta. We shared the preparation of the report on Edmonton's inner city health resources upon which much of this thesis is based. Dr. Greenhill's professional guidance as my supervisor and his friendship are gratefully acknowledged.

TABLE OF CONTENTS

CHAPTER PAGE

1. THE PROBLEM 1
    - Health and Development 1
    - The Crisis in Health Care 5
    - Health and Socio-Economic Class 7
    - Health in the Inner City of Edmonton 10
    - Conclusion 13
2. METHODOLOGY 17
    - Data Acquisition 17
    - The Research Process 17
    - Quality of the Data 20
    - Summary 22
3. THE INNER CITY: DEFINITION AND DEMOGRAPHIC DESCRIPTION 25
    - Definition of the Area 25
    - Demographic Description 28
    - Summary 45
4. THE INNER CITY: ENVIRONMENT AND LIFESTYLES 49
    - Introduction 49
    - Some Definitions 51
    - McCauley 57
    - Skid Row 60
    - Common Characteristics 63

CHAPTER PAGE

Anticipated Changes in the Area 64

Population Movement 67

Conclusion 68

5. MORBIDITY PATTERN 72

Introduction 72

Children 73

The Elderly 74

The Skid Row Population 75

Conclusion 77

6. COMMUNITY HEALTH RESOURCES AND THEIR UTILIZATION 80

Introduction 80

Inventory of Medically-Oriented Resources 80

Inventory of Social Welfare Agencies 85

Usage of Health Resources 88

Local Board of Health 88

Private Physicians 101

Hospitals 105

Other Health Resources 111

Social Agencies 117

Summary 121

7. APPROPRIATENESS OF THE HEALTH RESOURCES 124

Appropriateness of Existing Services 124

Gaps in Health Resources 131

8. THE ROLE OF COMMUNITY DEVELOPMENT IN IMPROVING HEALTH CARE 137

Introduction 137

CHAPTER PAGE

Community Development -- The Local Experience 139
Community Development in Health Care
Delivery Systems 143
A Community Health Facility in Edmonton's
Inner City 153
Summary 158
9. SUMMARY AND RECOMMENDATIONS 162
Summary 162
Recommendations 165
BIBLIOGRAPHY 167
APPENDIX 177

LIST OF TABLES

Table Page

1. Population Changes, Edmonton and Inner City, 1961-1971 30
2. Fertility Ratios, Aging Indices, and Dependency Ratios, Inner City and Edmonton, 1961 and 1971 37
3. Ethnic Origin of Inner City and Total Edmonton Populations, 1971 38
4. Marital Status of Inner City and Total Edmonton Populations, 1971 40
5. Education Levels of Inner City and Total Edmonton Populations, 1971 41
6. Average Total Family Incomes, Inner City and Edmonton Residents, 1971 43
7. Type of Housing, Inner City and Total Edmonton, 1971 44
8. Households by Type, Inner City and Total Edmonton, 1971 46
9. Types and Subtypes of Inner City People 54

LIST OF ILLUSTRATIONS

Map Page

1. The Inner City of Edmonton 26
2. Edmonton Census Tracts, 1971 27
3. Edmonton Local Board of Health Central Region 90
4. Distribution of Health and Social Agencies 122

Figure

1. Age and Sex Distributions Inner City and Edmonton 1961 31
2. Age and Sex Distributions Inner City and Edmonton 1971 32
3. Age and Sex Distributions Inner City 1961 and 1971 33
4. Age and Sex Distributions Inner City Area 1961 34
5. Age and Sex Distributions Inner City Area 1971 35

CHAPTER 1

THE PROBLEM

Health and Development

Health and development are inextricably interrelated. Ill health is increasing in the world today as a direct result of the pace and nature of social change. For many millenia humans lived in small groups attuned to their environment, and developed a lifestyle which met man's basic needs. But over the last few thousand years, man has changed. He has adopted lifestyles ill-suited to his basic biology. We are destroying our rural environments and are forcing ourselves to live in health and life destroying environments. "We are trying to twist our bodies, our emotional patterns and our cognitive structures into a way of living for which we are not biologically designed."[1]

The result of this is what Alvin Toffler calls future shock, the disease of not being able to cope with change itself.[2] The slums of Mexico City or Calcutta, or the villages of the Sahel, show these devastating effects; the cities of the rich world show it in our welfare agencies, mental hospitals, prisons and physicians' offices. Totalitarianism, famine, psychoneuroses, alcoholism -- all are indicators of these social pathologies.

Community development is one response to rapid social change. One of the ironies of community development, as Roland Warren has pointed out, is that it seeks both to create social change and to help people to cope with the ill effects of social change,[3] and so it both creates and attempts to alleviate ill health.

The two key concepts which underly this thesis are "development" and "health". Numerous theories of development exist. They fall into at least three groups: the first based on economic factors, the second on psychological factors and the third on political factors.

Economic theories have dominated the study of development for many years. These theories have resulted in confusing development with economic development and economic growth. One economist, for example, refers to "the phenomenon of modern development" as "a substantial and persistent increase in output per capita"[4] -- that is, economic growth. This emphasis on macroeconomic variables and measures, particularly national income aggregates, has been the most pervasive -- and detrimental -- effect of economic theories. In emphasizing economic growth, they divert attention from crucial components of development such as the human costs of the economic growth and the way the resulting wealth is distributed. Theories of development which ignore such factors are clearly inadequate.[5]

Psychological theories have not been as influential as economic theories in directing the course of development programmes. Psychological theories attempt to find the causes of development and underdevelopment in the personalities of individuals. Personality dynamics determine aspects of people's behaviour and the theories relate this to social organization and national development. People's "need for achievement", for example, is used by one theorist to explain the varying rates of economic growth in both the ancient and modern world.[6]

Psychologically based theories fail to allow for the influence of the many other variables in the development process besides human personality.[7]

When development is viewed as a political process it is seen as those structural changes within society that result in power being transferred from the elite to the masses. Paulo Freire, for example, finds the causes of underdevelopment to be in the institutional arrangements of a society. The process of development is the changing of these arrangements: the oppressed become free and thus able to develop their potentialities.[8] Denis Goulet uses "liberation" rather than "development" to describe this process, thereby emphasizing the crucial role in development of the transfer of power to the people.[9] These development theories, unlike the economic and psychological approaches, are explicitly value-based. They stress both the nature of the process of the change as well as its goals.

The current view of development is a pragmatic blend of the various theoretical stances, best expressed in the official United Nations "basic needs strategy". This strategy recognizes that the most basic component of development is the meeting of people's basic needs. This can best be attained through processes of popular participation in development at all levels of society.[10] The implications of this view are far-reaching, suggesting the transfer of wealth between and within nations, and the transfer of decision-making, and thus power from the wealthy elite to the people.

The concept of development used in this thesis is the pragmatic blend. "Development" is thus the process whereby people become able to satisfy their basic needs -- food, shelter, education and health care -- and to acquire control over those decision-making processes which determine the way they live their lives.[11]

The concept of "health" can be approached in many ways. Most modern definitions take a positive approach, best exemplified by the World Health Organization definition that "health is a state of complete physical, mental and social well being and not merely the absence of disease and infirmity".[12] This definition is, however, both idealistic and difficult to apply. Ill health is a concomitant of life, and the meaning of "well being" varies from culture to culture.

The 1967 Canadian Royal Commission on Health Services summarized this dilemma, concluding

> 1. that besides physical and mental well being health also implies social adjustment.
>
> 2. that even if we try to omit questions of social adjustment from our inquiry, we find that the physical and particularly the mental aspects of health cannot be separated from social and environmental influences.
>
> 3. that there is such a thing as "positive" health which is more than merely the absence of illness.
>
> 4. that we lack a means of directly measuring in quantitative terms positive health so that for the time being we must be content with measuring health defects rather than health as such.[13]

This approach is taken somewhat further in the 1974 Lalonde Report. The author suggests that the health field has four components, viz., human biology, environment, lifestyle and health care organization.[14] This framework is useful in classifying individual risk factors, but it omits the importance of interactions between the four components. The measurement of the contribution to health by any particular component is difficult.[15]

Other authorities stress social functioning:

> The real measure of health and disease is the ability of the individual to function in a manner acceptable to himself and to the group of which he is a part.[16]

These approaches are taken one step further by the humanistic school. Its image of health is a broad one based on a set of values relating to people's rights to self-determination and self-expression.[17] Ivan Illich puts this succinctly:

> Above all, health designates the range of autonomy with which a person exercises control over his own biological states and over the conditions of his immediate environment.[18]

When health is viewed in this manner, it comes close to the concept of development used in this thesis. "Health has come to mean the right to ever-widening opportunities for people to participate in the humanizing of their own development,"[19] as Howard puts it.

It is apparent that health and development are closely related. The school of community development which emphasizes the importance of process, and not the methods, programmes, or ideologies of community development parallels the humanistic approach to health. Community development authors like Biddle and Biddle,[20] who see participation as a desirable end in itself, are talking about the same process as Illich or Howard. Just as health is more than the absence of disease, so health care is more than the medical care of the sick. The broad humanistic approach to health care is closely related to community development.

The Crisis in Health Care

It is being said that North America is experiencing a crisis in health care. This claim is expressed by writers in popular magazines, scholarly journals, paper backs and academic texts. Over the last year the public has become increasingly aware of this "crisis" with the publication and heated discussion of Illich's Limits to Medicine. The crisis in health care has at least three dimensions:

1. the incidence of some diseases is increasing;
2. the public is more aware of health issues; and
3. the health care delivery system is increasingly unable to deal with current morbidities.

Venereal disease, heart disease, cancer, strokes, lung disease, child abuse, drug addiction and mental illness are all on the increase. In many regions of the world infant mortality is high. Tuberculosis is still too prevalent. Epidemics of communicable diseases still occur even though effective immunization is now available. Injuries and death due to lifestyles are likewise increasing.[21]

The public is becoming more aware of health issues. The ecological movement has publicised the dangers to health posed by insecticides, food additives and the work place. Governments now run campaigns pointing out the dangers of smoking, over-eating and physical inactivity. The consumer movement emphasizes people's rights to select themselves the type of medical care appropriate to their needs.

Finally, the crisis in health care is related to an increasing awareness of the inefficiencies within the health care delivery systems. Health care costs continue to rise at an alarming rate. Canada's national health expenditure in 1960 was $2.1 billion; in 1975 $11.5 billion. Annual per capita expenditure in that period rose from $118 to $503. The rate of increase in 1975 in health expenditure was 17.2 per cent, while the rate of inflation for the same period was 10.8 per cent.[22] Most of this increased expenditure goes to high-cost technology medical services (hospital costs account for over 50 per cent of total health expenditures).

Physicians are openly criticised. Modern medicine has become mechanistic. Doctors are said to have lost the "human touch". The doctor-patient relationship is replaced by "scientific" medicine. Doctors seem no longer able or willing to communicate with their patients.

Inequalities in the distribution of health care further contribute to the health care crisis. Physicians are becoming more specialized: 50 per cent of Canada's and 72 per cent of the United States' physicians are now specialists.[23] Their training is hospital based, and they tend to concentrate in city centres or the suburbs.

There is indeed a crisis in North American health care, but compared to most other regions of the world, our health care is excellent. This country's high level of health care highlights the contrasts between us and the poor world, and between the health status of the majority of Canadians and the poor and alienated minorities that live in our reserves, settlements and inner cities.

Health and Socio-Economic Class

The average expectation of life at birth in North America and Europe has doubled in the past 200 years. Canada's life expectancy at birth in 1978 is approximately 69 years for men and 77 years for women.[24] These figures reflect the high living standards enjoyed by the majority of Canadians.

The reduction in mortality can be attributed in the main to improved standards of living. Improvements in living standards, rather than medical advances, have contributed most to the control of epidemic diseases -- the main cause of high mortality in the past. Illich has accumulated evidence to support the contention that the professional practice of physicians cannot be credited with the elimination of old forms of mortality or morbidity, nor can it be credited with the increased expectancy of life which we now enjoy.[25] Inadequate nutrition, large families, little education, unemployment, low incomes -- all these are related to poor health in Canada and in the Third World.

Awareness of the relationship between social class and ill health and its consequences is nothing new. Rosen, in his excellent histories of health care, illustrates this with reference to Sir William Temple's 1677 essay on gout. Rosen writes:

> Noting that the disease usually affected the wealthy, the lazy and those who lived high, he also pointed out that the poor and those who have to work for a living are not immune to the disease. If working men are attacked by gout, "either they mind it not at all, having no leisure to be sick; or they use it like a Dog, they walk on, or they toil and work as they did before, they keep it wet and cold; or they are laid up, they are perhaps forced by that to fast more than before; and if it lasts, they grow impatient, and fall to beat it, or whip it, or cut it, or burn it, and all this while perhaps never know the very name of the Gout."[26]

Sir William was aware not only of the differences in morbidity between the classes, but also of the differences in responses to illness, two of the most important elements in health today.

It is not necessary to review the very extensive literature on the relationship of socio-economic class and health. Reviews are available in most texts,[27] and some key references are cited in later chapters. The literature clearly demonstrates that mortality, morbidity and illness behaviour are related to social class and other aspects of culture. Infant and neonatal mortality are higher in classes IV and V than in I and II. The lower classes die from different diseases: gastroenteritis among infants, bronchitis, pneumonia and tuberculosis are major causes of death among classes IV and V in the United Kingdom, but the rates of these diseases are low in classes I and II. In classes I and II diseases such as ischaemic heart disease and cirrhosis of the liver are more common.[28]

Not only are morbidity and mortality related to socio-economic class, but so is usage of preventive health services. A recent nationwide study in the United States of persons receiving such routine preventive health care as chest x-ray, pap smear tests, or physical examinations concluded that "family income and education level are directly related to the proportion of persons ever receiving each of the [eight] selected medical procedures. . . . Although the actual impact on the specific procedures varies, a pattern of increasing participation as income and education rise is clearly apparent."[29] This relationship applies not only to preventive health care, but to the use of medical facilities in general.[30]

Response to illness also varies with socio-economic class. Research shows the poor tend to ignore any but the most serious symptoms of illness,[31] but some authors reject this conclusion. They contend that it reflects society's lack of action to help the poor.[32] Certainly there are some groups in Canada who place a low priority on health care, while others perceive health care as being inaccessible.

Cultural factors are of great importance in health and in illness behaviour. In many traditionally-oriented Papua New Guinea societies the people do not consider even serious skin ailments to be diseases. Members of Boston's poor Italian community had quite different perceptions of illness and treatment from those of their non-Italian physicians, as Gans clearly established.[33] And in Edmonton, as later chapters will show, members of the ethnic minorities who live in the inner city and the men of the skid row culture experience different diseases and exhibit different illness behaviour from the people of the rest of the city.

Health in the Inner City of Edmonton

The inner core of Edmonton, specifically the neighbourhoods of McCauley and Boyle Street, is an "underdeveloped area" compared to the rest of the city. As is shown in Chapters 3 and 4, the people in these neighbourhoods have a lower standard of living and have less control over the circumstances that determine how they live. These dynamics are reflected in their relatively poor state of health and their perceived lack of access to health care facilities. Some fifteen thousand people live in the inner city, leading a variety of lifestyles: the elderly, the isolates, the ethnic minorities, the transients and the skid row residents.

Health professionals and other knowledgeable outsiders, as well as some people of the area, have long been concerned about the problems of health in the inner core of Edmonton. The quality of health care provided the people of the city at large is generally of a high standard. It has been felt by some concerned and involved individuals that something special, and different, needs to be done to improve the health status of the inner city population. The main health problems of these people are said to be diseases virtually eliminated from the population at large. It would appear society has been unable, or unwilling, to apply existing health care know-how to helping those living in this disadvantaged neighbourhood.

The Inner City Field Workers Group, an informal association of personnel from voluntary and statutory agencies who are active in

Edmonton's inner city, has long wished that specific action be taken to overcome the deficiencies in health care in the area. Accordingly, they established a working sub-committee which produced a report in September 1975 setting out their concerns in some detail. They concluded, inter alia, that a new type of health facility -- a clinic -- should be established in Boyle Street or McCauley.[34] (Other reports have included similar recommendations.[35])

Their views were conveyed to the Medical Officer of Health for the City of Edmonton, who was already aware of many of the problems that they raised. In particular he was aware of (a) the allegedly inappropriate use being made of the Emergency Departments of the city's hospitals, especially the Royal Alexandra Hospital, (b) the lack of doctors practising in the inner core of the city, and (c) the many unrelated and diverse studies made of the area in recent years. The Local Board of Health by statute cannot provide medical care. Nursing and social service personnel are inadequate in numbers to offer primary medical and allied health services to the inner city.

No clear evidence was available to support the contention that the health and medical care of the people of the inner city is poorer than that of Edmonton's citizens in general, nor has it been proven that a "community clinic" is the best way of handling such a problem. For government or voluntary agencies to respond by establishing a clinic without such information would be folly. Numerous programmes have failed because they were undertaken without first determining the exact nature of the problem and how it might best be overcome.

The Department of Community Medicine of the University of Alberta was approached by the Local Board of Health to undertake action research in this area. The project was considered to be best handled in three phases.

Phase 1, to determine the health needs of Edmonton's inner core area, and the adequacy and appropriateness of its health and health related services, agencies and facilities.

Phase 2, to design and plan an innovative health programme for this particular area of Edmonton should the findings of Phase 1 indicate such a need.

Phase 3, to establish methods of evaluation of such a programme once established.

The writer was recruited to work on Phase 1 as a research assistant. This phase of the work was completed in April 1977. It is hoped that Phase 2 will commence in 1978.

A major conclusion of Phase 1 was that a new kind of medical and health care facility -- new for Edmonton, that is -- be established in the inner city, appropriate to the unique characteristics of the people of the area.[36] Clearly such a facility could be part of a broader community development programme for the area, and since such a programme is now commencing under the auspices of the City Planning Department, this is a highly feasible proposition. In Edmonton and elsewhere we have observed a pervasive trend towards an increasing degree of citizen participation in a wide range of health activities. Such participation has ranged from tokenism, through advice and consultation, and in other cities, to complete community control. The issue of community control of health facilities, especially of community clinics, has been hotly debated in the United States over the last decade. This is not an issue in Edmonton at present. It does, however, raise the crucial question: if a neighbourhood health centre or clinic is a solution to the inner city's health problems, in what ways can and should the local communities be involved?

Conclusion

The objective of this thesis is to investigate the following:

1. The factors which determine the patterns of utilization of health care services in the inner city of Edmonton.

2. The appropriateness of the existing health care services for the inner city population.

3. The role of community development in meeting the health care needs of this population.

The study will propose a community development project, based on the findings of these investigations, which aims to improve the health of the people of Edmonton's inner city.

This thesis is designed to assist health planners, field workers and researchers interested in the inner city. It will also assist the staff engaged in Phase 2 of the inner city project, and the planners and field staff of the proposed Boyle Street/McCauley community development project.

Much of the content of the report on Phase 1 of the inner city project, Community Health Resources for the Inner City of Edmonton, is incorporated into later chapters. It is hoped that the new material included in this thesis will add to the value of that report.

FOOTNOTES

1. John Raser, "Predictions and Proposals", in Social Work in Australia, ed. Philip J. Boas and Jim Crawley, p. 261.

2. Alvin Toffler, Future Shock.

3. Roland L. Warren, Truth, Love, and Social Change, p. 79.

4. Richard T. Gill, Economic Development: Past and Present, p. 4.

5. One very influential economic theory of development has been Rostow's "big push" theory. See W. W. Rostow, The Stages of Economic Growth.

6. David C. McClelland, The Achieving Society.

7. Examples of psychologically based theories of development are ibid. and Everett E. Hagan, On The Theory of Social Change.

8. Paulo Freire, The Pedagogy of the Oppressed.

9. Denis Goulet, "'Development' . . . or Liberation?", International Development Review 13, no. 3 (1971): 6-10.

10. The international basic needs strategy was adopted by the United Nations General Assembly on 21 December 1976. See United Nations Children's Fund, A Strategy for Basic Services, p. 4. The popular participation approach is discussed in United Nations, Popular Participation in Decision Making for Development.

11. This understanding of development comes especially from the writings of Dudley Seers and Denis Goulet (see bibliography).

12. World Health Organization constitution.

13. Robert Kohn, The Health of the Canadian People, p. 15.

14. Marc Lalonde, A New Perspective on the Health of Canadians, pp. 31-34.

15. Canada, Department of National Health and Welfare, Health Field Indicators: Canada and Provinces, p. 30.

16. W. Harding le Riche and Joan Milner, Epidemiology as Medical Ecology, p. 82.

17. For example, Virginia L. Wang, "Social Goals, Health Policy and the Dynamics of Development as Bases for Health Education", International Journal of Health Education 10, no. 1 (1977): 14.

18. Ivan Illich, Limits to Medicine, p. 242.

19. Lawrence C. Howard, "Decentralization and Citizen Participation in Health Services", Public Administration Review 32 (special issue October 1972): 702.

20. William W. Biddle and Loureide J. Biddle, The Community Development Process.

21. This is based on Irene G. Ramey, "The Crisis in Health Care: Fact or Fiction", in Health Care Issues, ed. Madeleine Leininger and Gary Buck, p. 17.

22. Canada, Department of National Health and Welfare, Health Field Indicators, pp. 41-42, 80; Canada, Department of Finance, Economic Review, May 1977, p. 175.

23. Ibid., p. 87, and Richard J. Margolis, "Why 117 Medical Schools Can't be Right", Change, October 1977, p. 26.

24. Canada, Department of National Health and Welfare, Health Field Indicators, p. 59. This could be compared with the average life expectancy at birth of the world's 29 least developed countries, of 42 years. See John W. Sewell, The United States and World Development: Agenda 1977, (N.Y.: Praeger, for the Overseas Development Council, 1977), pp. 160-164.

25. Illich, Limits to Medicine, pp. 15-22.

26. George Rosen, From Medical Police to Social Medicine, p. 43.

27. For example, David Mechanic, Medical Sociology, pp. 242-270; Rodney M. Coe, Sociology of Medicine, pp. 58-59; Frank Riessman, Jerome Cohen and Arthur Pearl (eds), Mental Health of the Poor.

28. Coe, Sociology of Medicine, p. 58.

29. United States, Department of Health, Education, and Welfare, Use of Selected Medical Procedures Associated with Preventive Care, United States - 1973, p. 2.

30. Mechanic, Medical Sociology, p. 267.

31. Coe, Sociology of Medicine, p. 112.

32. George A. Silver, "What Has Been Learned About the Delivery of Health Care Services to the Ghetto?", in Medicine in the Ghetto, ed. John C. Norman, p. 66.

33. Herbert J. Gans, The Urban Villagers, pp. 140-141.

34. Inner City Field Workers Group, "Health Service Delivery in McCauley, Boyle Street, and Riverdale Communities", p. 7.

35. For example: Janet Jellard, "Community Geriatrics in Edmonton"; A. Joy Young, "Nursing Services, Single Men's Hostels, Edmonton and Calgary"; and Edmonton Women's Shelter, Ltd., *A Study of the Developmental Program of the Women's Overnight Shelter, Edmonton*.

36. D. N. McDonald, Stanley Greenhill and Lory Laing, *Community Health Resources for the Inner City of Edmonton*, p. 158.

CHAPTER 2

METHODOLOGY

Data Acquisition

To achieve the objectives of the study, two types of data were needed: (1) data from field research, and (2) data from library research. Field research in the inner city and its agencies was required to obtain data about the study area, particularly data on the morbidity pattern of the area, the services provided by the various agencies, the ways these agencies are utilized by inner city people, and on their prevailing lifestyles.

Library research was used to amplify and supplement the field data, particularly in the areas of the inner city demographic patterns, the concepts of health and development, inner city health as reported for Edmonton and elsewhere, and the role of community development in inner city health care. No field trips were made to other cities but information about services and problems in inner city health and community development was obtained from published sources.

The Research Process

The research was commenced in May 1976. The first step was to undertake a critical review of the literature on the inner city. It quickly became apparent that over the years a great many studies had been done of Boyle Street and McCauley, and reports written (the bibliography lists many of these). Edmonton's inner city seems to attract the attention of researchers; in fact, while the field work was being carried out, field workers from at least three other research projects were encountered in the area! The existing literature on Edmonton's inner city varies in quality. Much of it is quite outdated. Very little has been written on the health problems found in Edmonton's inner city. The majority of published reports are related to physical planning for the area.

Field work was undertaken from May to August 1976, and data on such things as agency activities generally refer to what was current at that time. It began with general exploratory and orientation discussions with the Medical Officer of Health for the City of Edmonton, and the Supervisor of the city's Central Regional Clinic. Subsequently, visits were made to over 20 agencies and interviews were held with over 40 professional and voluntary personnel engaged in the health field in the inner city. The objective of these visits was to obtain data on the services provided and the patterns of usage of these services. The lifestyles and morbidity patterns of the inner city people were also studied. In an effort to evaluate the appropriateness of these services and to identify any gaps, focussed interviews with agency staff were undertaken. Data contained in published brochures, agency reports and files, etc., were analysed.

No systematic interviewing of the resident and transient people of the inner city was attempted. In the course of the field work, however, the writer spent many hours in the inner city agencies, taverns, cafes and other places frequented by the local people. Many opportunities arose for casual conversations and not-so-casual observations. Data and impressions obtained from these contacts were valuable in enabling a cross-check of data obtained from agency sources.

The research strategy used was the one considered most appropriate to achieve the objectives of the study, viz., to investigate the health services of the inner city, their appropriateness, and the role of community development in improving health. The objective was not to test or substantiate any specific hypotheses, but rather to obtain a clear description of the matters under study and from this description to draw generalizations that could act as guides to subsequent policy formulation and action.

Both quantitative and qualitative research strategies were used, and the data presented in later chapters reflect this. The qualitative methodology seems particularly appropriate in this instance, as it is well suited to obtaining descriptions of the empirical world and to learning about the causal processes in relationships between people and institutions.[1] In-depth interviews, participation in agency activities and other aspects of field work -- in other words, the qualitative methodology -- enabled the writer to obtain a substantial degree of personal knowledge and understanding of the empirical situation in the inner city. The value of this methodology, as one authority puts it, is that it "allows the researcher to 'get close to the data', thereby developing the analytical, conceptual, and categorical components of explanation from the data itself."[2]

On completion of field work, a further literature review was undertaken, the published demographic data were analysed and a report prepared for public use.[3] The report received favourable publicity in the press (Edmonton Journal 14th, 18th and 22nd April 1977) and on radio and television. An essential component of the research strategy was to feed back to the informants the conclusions of the study. Copies of the report were distributed free of charge to all the relevant agencies. In addition, a presentation was given to the Inner City Field Workers Group on 14 April 1977, outlining the contents of the report. The public response to the report was most gratifying, and comments and reactions from a wide variety of readers provided additional feedback.

Subsequently, a more detailed literature review was undertaken to provide the theoretical and comparative perspectives that are essential to this thesis.

Quality of the Data

The nature and quality of the data used in this study vary considerably. Some are of known validity and reliability, such as the demographic data from Statistics Canada, or the numbers and types of patients using a particular service.

Other data are less "hard", e.g. the data on morbidity. (See Chapter 5.) Useful data on morbidity are contained in the files of the Alberta Health Care Insurance Commission, and the Alberta Hospitals Commission, but these were not available for this study. For technical and administrative reasons, data are generally not available on specified small areas of the city. It is hoped computer systems in the future will code data utilizing postal codes as one variable, so that data retrieval may be possible according to specific localities. However, confidentiality and personal liberties legislation may preclude such a development.

Important data came from the interviews with inner city agency personnel. Data derived from these sources are quite different in nature from statistical or demographic data. Although largely qualitative in nature, the interview data are of great value in a study such as this. They are based on people's observations and experiences. They are not speculative nor conjectural. Intelligent perceptive professionals and volunteers who have worked in the inner city for years develop knowledge and understanding of the area, its people and their needs. Many have developed systems of data appropriate to their own needs and available resources.

When it is reported, as in Chapter 6 for example, that one of the reasons that elderly people go to a hospital emergency department is to try to overcome feelings of isolation and loneliness, and obtain some human care and attention, the writer is not reporting the findings of a carefully constructed, administered and scored questionnaire. Rather what is reported is the view of a number of reliable, competent, perceptive people who work daily with the elderly in their homes and in hospitals, and who are knowledgeable from experience about the motivations of the elderly. The reliability of these expressed opinions has been assessed by comparing the views of a number of different involved workers. A high degree of concurrence has been observed.

From time to time anecdotes from real life were reported to illustrate general points being made. They have not necessarily been included as typical examples, but are used as a type of data which, it is hoped, will help the reader to have empathy with the inner city people whose problems are being discussed.

Evidence is available which suggests that the qualitative research methods used in this study have a satisfactory level of validity. As mentioned above, the report Community Health Resources for the Inner City of Edmonton, which contained most of the qualitative data and conclusions presented in later chapters, was widely circulated and read. Validation came from a number of sources:[4]

1. From independent investigators. A Master of Social Work student has critically studied the report and commented favourably on it.[5]

2. From outside sources. The findings of this study concur closely with the published conclusions of researchers who have worked in other cities.

3. From self-confrontation or internal consistency. The total complex of variables that make up human social life enter into the research as the researcher is immersed in the field situation. If the findings are internally consistent it suggests that the methodology and conclusions are valid, that is, they accurately represent real life. Many readers of the report have said that it "makes sense" or is internally consistent.

4. From review by subjects. The interviewees have almost unanimously commended the authors of the inner city report on the correctness of the reported data and findings. This implies a high degree of validity.

Summary

The objectives of this thesis determined the research methodology. A number of different strategies were used, both quantitative and qualitative in nature. Besides a literature review and analysis of published data, in-depth focussed interviews were held with inner city agency personnel and others. This qualitative research strategy seems particularly appropriate in this instance as it enabled the writer to "get close to the data" and develop a substantial degree of understanding of the empirical social world of the inner city and its health problems. In the writer's view, the combination of research strategies employed has a high degree of validity and enabled the objectives of the study to be realized.

FOOTNOTES

1. Stephen Cole, The Sociological Method, pp. 163-166.

2. William J. Filstead, Qualitative Methodology, p. 6.

3. D. N. McDonald, Stanley Greenhill and Lory Laing, Community Health Resources for the Inner City of Edmonton.

4. These are validation methods recommended in the context of case studies. They seem equally appropriate here. See Paul B. Foreman, "The Theory of Case Studies", in Research Methods, ed. Billy J. Franklin and Harold W. Osborne, pp. 201-202.

5. V. Cerezke, in a term paper for the University of Calgary M.S.W. course Social Research 541. Instructor Dr. G. Kupfer. Typescript, December 1977.

CHAPTER 3

THE INNER CITY

DEFINITION AND DEMOGRAPHIC DESCRIPTION

DEFINITION OF THE AREA

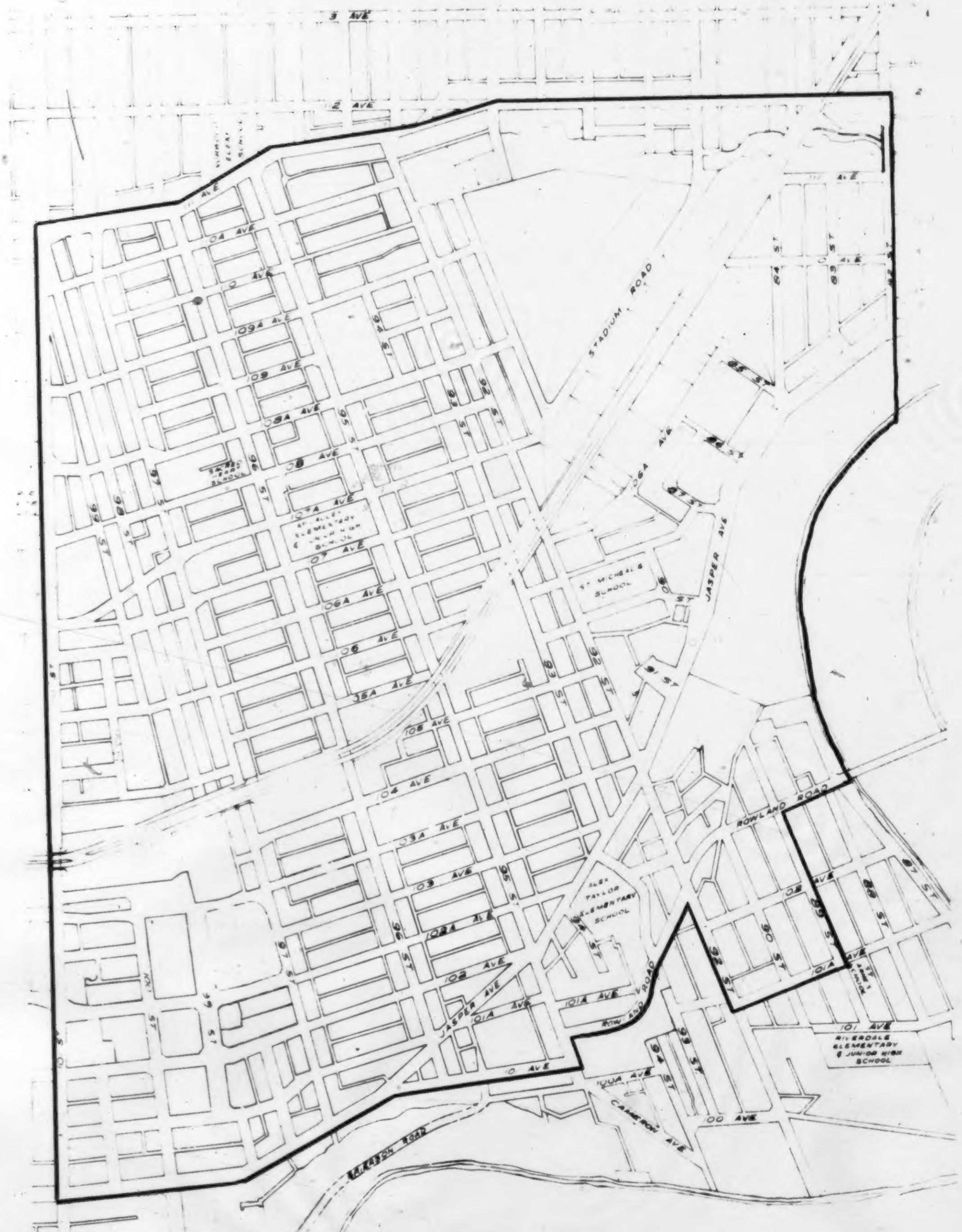
The study area is the "inner core" of the city of Edmonton, specifically the neighbourhoods of Boyle Street and McCauley. Although there is no consensus on the exact boundaries of these areas, for our purposes they are defined as including the area bounded in the east by 82nd Street, in the north by 112th Avenue and Norwood Boulevard, in the west by 101st Street, and in the south by the north bank of the North Saskatchewan River Valley. (See Map 1).

The locality referred to as Boyle Street is the southern half of the study area, that is, south of the C.N.R. railway line and 105th Avenue, while McCauley is the area north of this boundary.

This area can also be defined in terms of the 1971 Census of Canada boundaries. (See Map 2). Census Tract 45 of the City of Edmonton is McCauley West, that is, the section of McCauley (as defined above), which lies west of 96th Street. Census Tract 44 is McCauley East, that is, the part of McCauley east of 96th Street. The Boyle Street area is that part of Census Tract 34 which is north of the North Saskatchewan River bank, that is, Census Tract 34 excluding Enumeration Areas 052, 053, 101 and 102. These Enumeration Areas compose the community of Riverdale and the adjacent area to the west. They have

MAP 1

THE INNER CITY OF EDMONTON

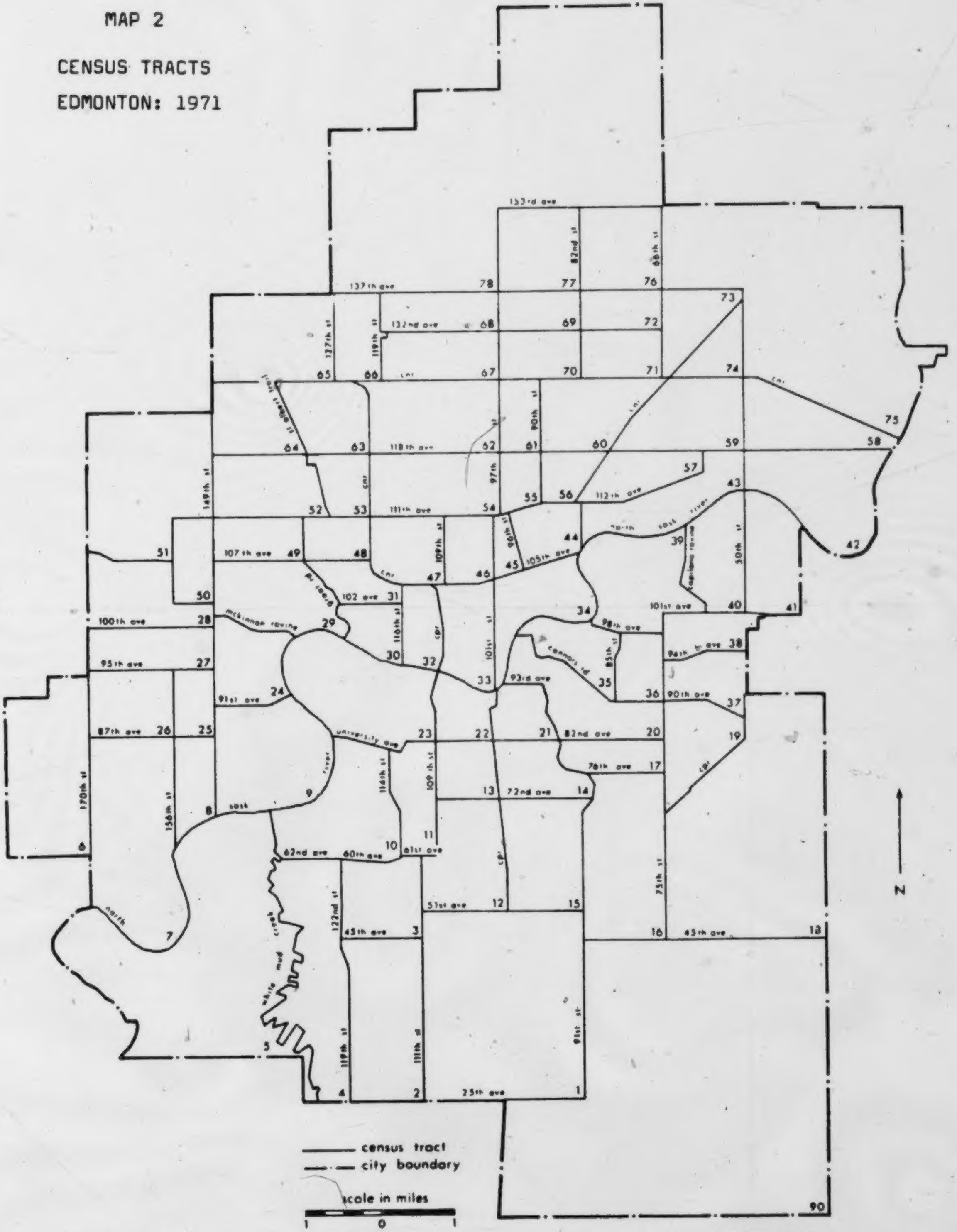

STADIUM ROAD
JASPER AVE
ROWLAND ROAD
ST. MICHAEL'S SCHOOL
ALEX TAYLOR ELEMENTARY SCHOOL
RIVERDALE ELEMENTARY & JUNIOR HIGH SCHOOL
101 AVE
100 AVE
CAMERON AVE
ALBERTA COLLEGE

SCALE: 1" = 1000'

MAP 2

CENSUS TRACTS

EDMONTON: 1971


153rd ave
82nd st
66th st
78
77
76
137th ave
73
132nd ave
68
69
72
127th st
119th st
65
66
cnr
67
70
71
74
cnr
st albert trail
90th st
97th st
cnr
75
64
63
118th ave
62
61
60
59
58
149th st
cnr
57
111th ave
52
53
54
55
56
112th ave
43
north
sask
river
51
107th ave
49
48
109th st
96th st
44
39
kapiano ravine
50th st
42
cnr
47
46
45
105th ave
50
groat rd
102 ave
31
34
101st ave
40
41
100th ave
28
mckinnon ravine
29
116th st
cpr
101st st
98th ave
38
connors rd
85th st
94th ave
95th ave
27
30
32
33
93rd ave
35
36
90th ave
37
91st ave
24
87th ave
26
25
university ave
23
22
21
82nd ave
20
19
114th st
109th st
76th ave
17
cpr
river
9
13
72nd ave
14
170th st
156th st
8
sask
11
6
62nd ave
60th ave
10
61st ave
cpr
122nd st
75th st
north
7
51st ave
12
15
white mud creek
45th ave
3
16
45th ave
18
119th st
111th st
91st st
5
4
2
25th ave
1
90
N
census tract
city boundary
scale in miles
1
0
1

MAP PREPARED BY
POPULATION RESEARCH LABORATORY
UNIVERSITY OF ALBERTA

been excluded from our definition of Boyle Street as they are considered to be both physically and socially separate from the inner city and particularly different from the remainder of Census Tract 34. Riverdale is characterized by a higher proportion of families, especially young families, higher average incomes, higher rates of home ownership, and a much greater degree of community cohesion. Evidence for this is seen in the active nature of the Riverdale Community League and the successful organization and action of the local residents to oppose aspects of city planning which could have led to the destruction of their community. In addition, the Riverdale residents are orientated to the south rather than north to the inner city, as many of their children go to school on the south side of the river, and residents tend to make considerable use of the shopping and other commercial facilities of the Whyte Avenue area. Field workers in both Riverdale and the inner city generally accept the definition of Boyle Street utilized in this study.

DEMOGRAPHIC DESCRIPTION

A demographic description of the inner city is necessary for a number of reasons. First, it provides base data which can be used in subsequent research, as the trends over time in the key demographic variables have major implications for health service delivery. Secondly, it provides data from which we can infer aspects of social structure; this is necessary to avoid unfounded conjecture, as the "conventional wisdom" about inner city populations is often incorrect. For example, the common assumption that the inner city population is relatively homogenous is refuted by the data, as the discussion in the next chapter will show. Thirdly, the demographic data constitute much of the independent variable in discussions which relate social class and such concerns as illness behaviour or access to health resources.

Total Population

The total population of the study area at the time of the 1971 census was 15,425, or 3.5 per cent of Edmonton's total population of 438,425. The inner city population had declined by 10 per cent from 1961 to 1971 (from 17,150 to 15,425). In the same period Edmonton's total population had risen by 36 per cent (from 322,238 to 438,425). The fall in the inner city population has almost certainly continued since the time of the 1971 census, especially in the Boyle Street and McCauley West areas as the pattern of land use is changing from residential to commercial and public uses.

Boyle Street had 5,495 people in 1971 (35 per cent of the study area's population), and McCauley had 9,930 (65 per cent of the total).

Of the total inner city population, 57 per cent were males: 64 per cent males in Boyle Street and 53 per cent males in McCauley, compared with 45 per cent males for the City of Edmonton as a whole. (See Table 1.)

Age Structure of the Inner City Population

The age and sex structure of the inner city is illustrated in Figures 1 to 5. Unlike the total Edmonton population there are more males than females in most categories after 25 years of age. In both 1961 and 1971 the inner city had a much smaller proportion of children and young adults (i.e. less than 19 years of age). In turn the proportion of elderly (particularly those over 65 years) was much higher in the inner city.

TABLE 1

POPULATION CHANGES, EDMONTON AND INNER CITY, 1961-1971

AREA	YEAR	
	1961	1971
McCauley (CTs 44 & 45 - 1971 39 & 15 - 1961)	11,128	9,930
Boyle Street (CT 34 - 1971; 20 - 1961)*	6,022	5,495
Edmonton Total	322,238**	438,425***

*Census Tract 34 minus enumeration areas 101, 102, 052, and 053 in 1971.

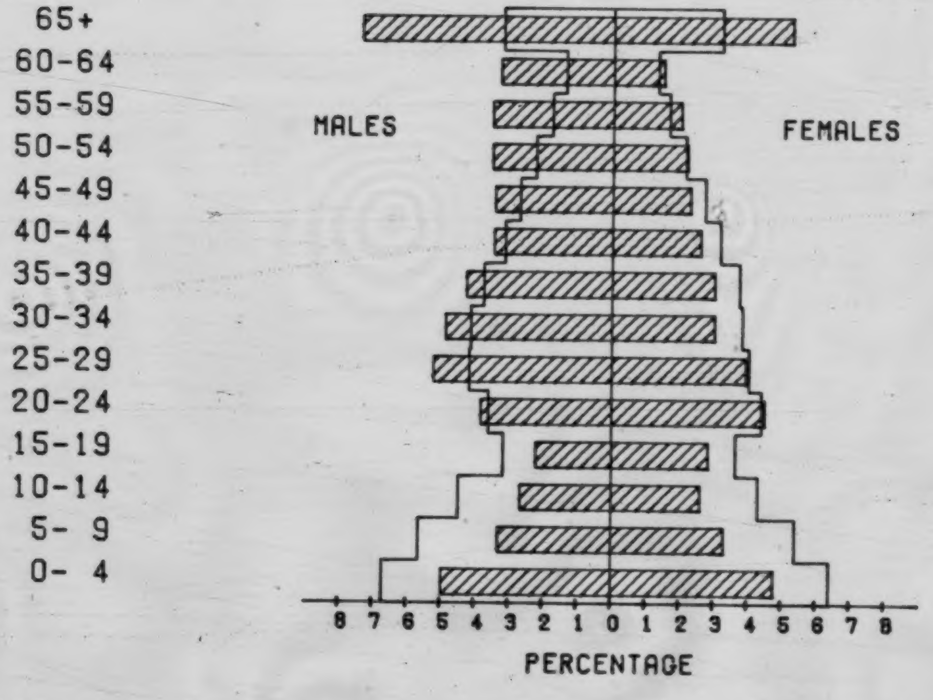
Census Tract 20 minus enumeration areas 2, 3, 4, 5, and S-140 in 1961.

Source: Statistics Canada enumeration area printouts.

**Dominion Bureau of Statistics, 1961 Census of Canada, Census Tract Bulletin, "Population: Characteristics by Census Tracts", Catalogue 95-626.

***Statistics Canada, 1971 Census of Canada, Census Tract Bulletin, "Population and Housing Characteristics by Census Tracts, Edmonton", Catalogue 95-727.

Figure 1

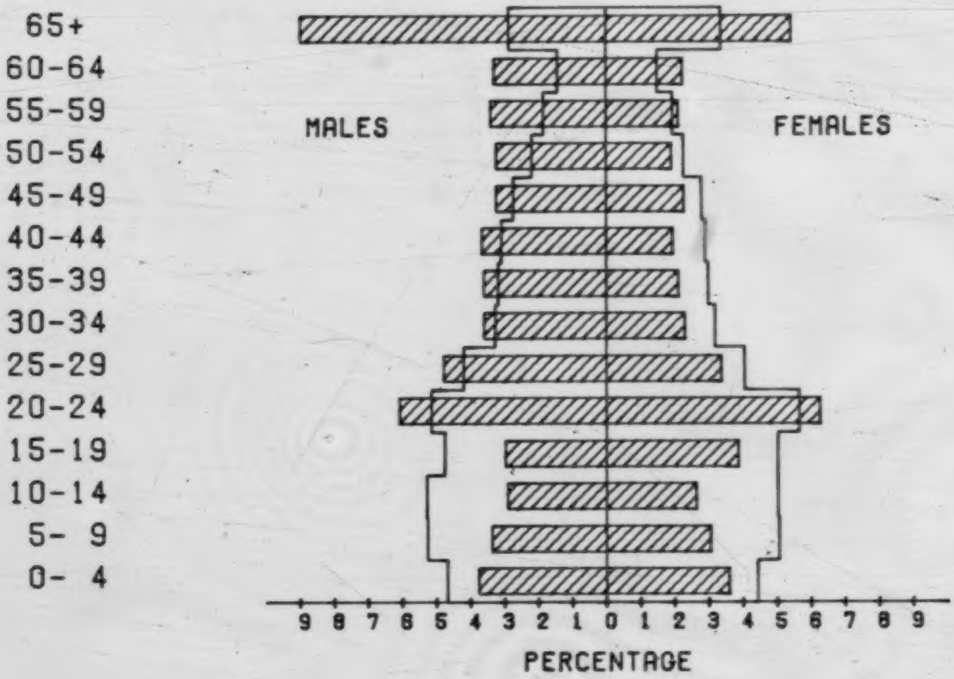


AGE AND SEX DISTRIBUTIONS

INNER CITY AND EDMONTON 1961

☐ EDMONTON
▨ INNER CITY

Figure 2

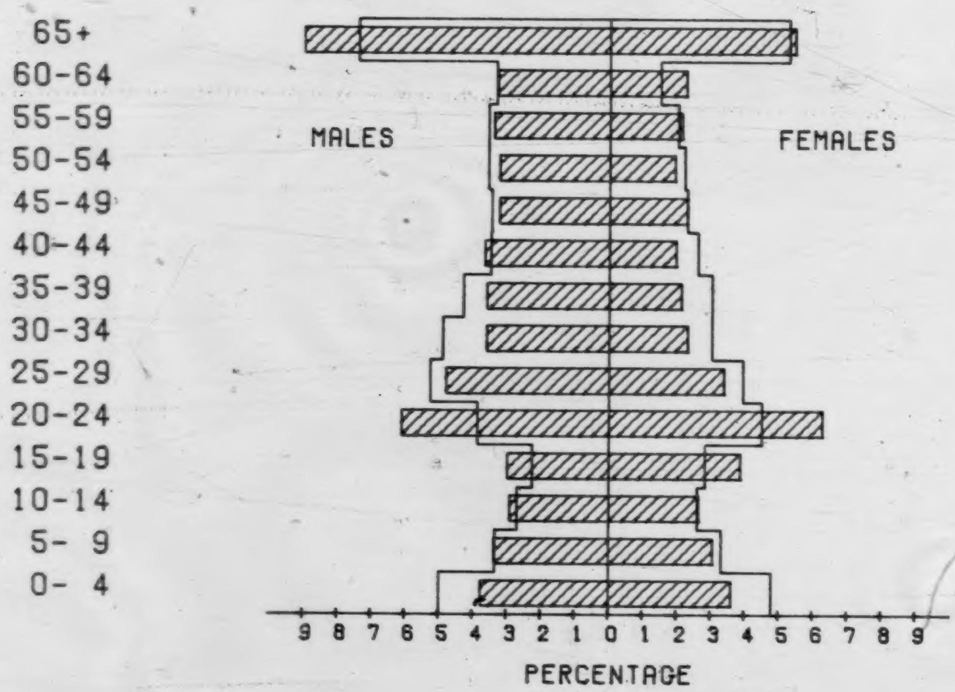


AGE AND SEX DISTRIBUTIONS

INNER CITY AND EDMONTON 1971

□ EDMONTON
▨ INNER CITY

Figure 3

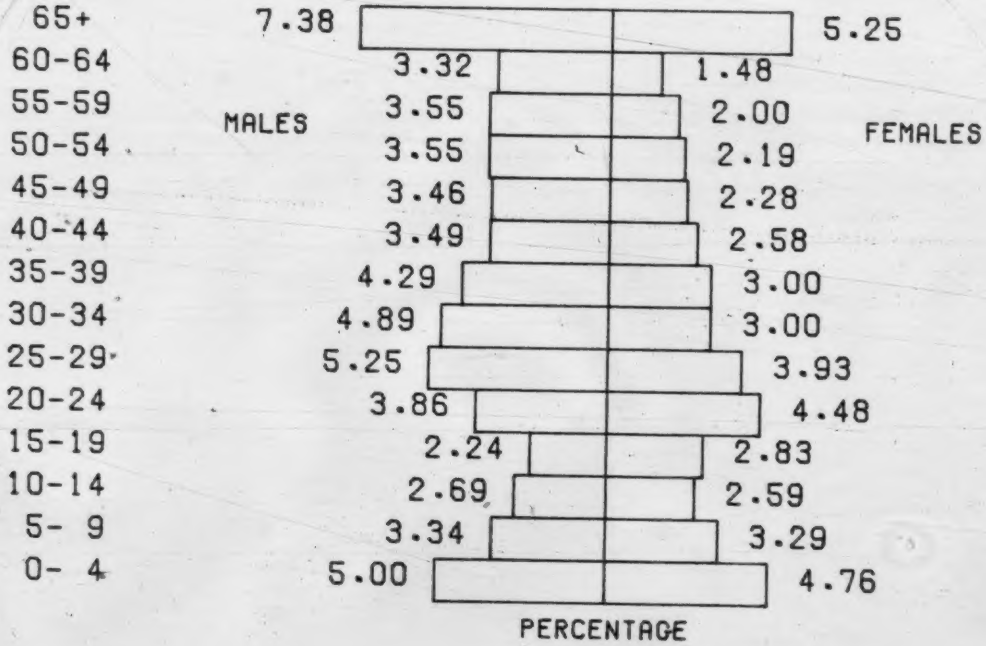


AGE AND SEX DISTRIBUTIONS

INNER CITY 1961 AND 1971

☐ 1961
▨ 1971

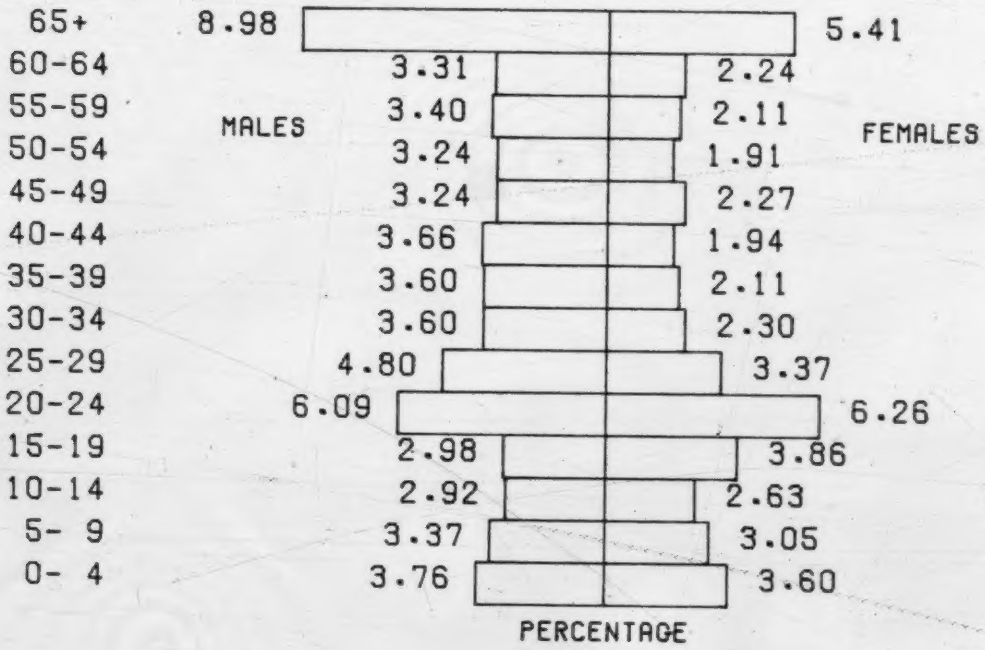
Figure 4



AGE AND SEX DISTRIBUTION

INNER CITY AREA 1961

Figure 5



AGE AND SEX DISTRIBUTION

INNER CITY AREA 1971

Between 1961 and 1971 these distinguishing features of the inner city population became more pronounced (see Figures 3 to 5). In 1971 there were even fewer children under five years and more people, particularly males, over 65 years. There was also a decrease in those between the ages of 25 and 39 years.

The significance of these characteristics can be seen in Table 2. The inner city has a lower fertility ratio than the City of Edmonton as a whole because it has a lower proportion of children (0 to 4 years) but only a slightly lower proportion of women of childbearing age (15 to 44 years). The difference between the inner city and Edmonton was less pronounced in 1971 than 1961. This is because the Edmonton fertility ratio declined by 34 per cent during this period, while the inner city fertility ratio declined by only 25 per cent.

The aging index for the inner city is much higher than that of the city as a whole (Table 2). The increase in the index for the inner city between 1961 and 1971 was also much higher (Table 2).

The overall dependency ratio for Edmonton was higher than the inner city dependency ratio in 1971 (Table 2), primarily because of the youth component of the ratio in the Edmonton aggregate.

Ethnic Composition

Table 3 provides information on the different ethnic origins of the inner city and total Edmonton populations. The largest proportion in both populations in 1971 was of British origin. However only 26 per cent of the inner city population fell within this group, compared to almost half (44 per cent) of the Edmonton population.

In turn, the inner city had higher proportions of Asians, Hungarians, Italians, Poles, Russians, Ukrainians and "Other" ethnic

TABLE 2

FERTILITY RATIOS, AGING INDICES, AND DEPENDENCY RATIOS, INNER CITY AND EDMONTON

1961 AND 1971

	INNER CITY		EDMONTON	
	1961	1971	1961	1971
Fertility Ratio*	492.2	370.9	576.5	383.5
Aging Index**	58.3	74.5	19.8	21.0
Dependency Ratio***	52.2	50.9	49.1	69.6

$$\text{*Fertility Ratio} = \frac{\text{Population 0-4 years}}{\text{Females 15-44 years}} \times 1000$$

$$\text{**Aging Index} = \frac{\text{Population 65+}}{\text{Population 0-14 years}} \times 100$$

$$\text{***Dependency Ratio} = \frac{(65+) + (0\text{-}14)}{\text{Population 15-64}} \times 100$$

TABLE 3

ETHNIC ORIGIN OF INNER CITY AND TOTAL EDMONTON POPULATIONS, 1971

(in per cent)

ETHNIC ORIGIN	INNER CITY CT44	CT45	CT34*	EDMONTON TOTAL
British	26.5	22.2	29.5	44.2
French	5.7	9.0	6.5	6.7
Asiatic	6.4	3.3	13.8	2.1
German	8.2	8.0	7.1	12.4
Hungarian	0.2	1.2	1.6	0.7
Italian	13.8	4.0	0.7	2.0
Netherlands	2.0	1.0	3.0	3.3
Polish	4.8	9.3	5.6	3.5
Russian	0.3	0.7	1.1	0.5
Scandanavian	2.5	3.0	4.9	4.8
Ukrainian	15.6	26.2	14.8	13.3
Other	14.0	12.1	11.4	6.5
TOTAL	100.0	100.0	100.0	100.0

*Census Tract 34 minus enumeration areas 101, 102, 052, and 053.

Source: Statistics Canada enumeration area print-outs.

origins. Included in the "Other" category are 540 Indian and Eskimo people in the inner city area. This figure represents 3.5 per cent of the study area's population and 0.9 per cent of the total city population. Unfortunately census figures on the number of Indians and Eskimos in a given area are not reliable indicators of the "native" population. The census counts only "treaty" or "status" Indians. By eliminating non-treaty Indians and Metis, the census thereby eliminates a major portion of the native cultural groups. With this in mind the census figures must not be taken as an accurate indication of the "native" population discussed in this study.

A number of estimates of the size of this population are available. One study suggests that in 1970 there were about 4,000 native persons in the study area, and the number was suspected to be increasing.[1] Brody estimated that there were between 700 and 1,000 natives in the skid row area alone at the time of his field work,[2] and a recent estimate suggests that there are now about 4,000 native people in Boyle Street and McCauley.[3] The accuracy of these estimates is very difficult to assess.

Marital Status

The population by marital status of McCauley East (Census Tract 44) is very similar to that of the city as a whole. (See Table 4). However, McCauley West (Census Tract 45) and Boyle Street (Census Tract 34) have higher proportions who are single or widowed, and slightly more who are divorced.

Education Levels

The information presented on the highest level of education attained (Table 5) refers to those attending and those not attending

TABLE 4

MARITAL STATUS OF INNER CITY AND TOTAL EDMONTON POPULATIONS, 1971

(in per cent)

MARITAL STATUS	INNER CITY CT44	INNER CITY CT45	INNER CITY CT34*	TOTAL EDMONTON
Single, under 15 years	26	15	14	30
Single, 15 years and over	21	33	37	19
Married	45	39	35	46
Widowed	5	9	9	3
Divorced	3	4	5	2
TOTAL	100	100	100	100

*Census Tract 34 minus enumeration areas 101, 102, 052, and 053.

Source: Statistics Canada enumeration area printouts and Statistics Canada, 1971 Census of Canada, Census Tract Bulletin, "Population and Housing Characteristics by Census Tracts, Edmonton," Catalogue 95-727.

TABLE 5

EDUCATION LEVELS OF INNER CITY AND TOTAL EDMONTON POPULATION, 1971

HIGHEST EDUCATION LEVEL ATTAINED	INNER CITY						TOTAL EDMONTON	
	CT 44		CT 45		CT 34*			
	NUMBER	%	NUMBER	%	NUMBER	%	NUMBER	%
Less than Grade 9	3075	50	1565	54	2110	50	149,925	38
Grades 9-10	960	15	560	19	900	21	73,245	18
Grade 11	470	8	210	7	380	9	41,160	10
Grades 12-13	1240	20	360	13	630	15	87,325	22
Some University	315	5	105	4	110	2	24,140	6
University Degree	145	2	90	3	115	3	22,750	6
TOTAL	6195	100	2890	100	4245	100	398,545	100

*Census Tract 34 minus enumeration areas 101, 102, 052, and 053.

Source: Statistics Canada enumeration area print-outs and Statistics Canada, 1971 Census of Canada, Census Tract Bulletin, "Population and Housing Characteristics by Census Tracts, Edmonton," Catalogue 95-757.

school full-time. The inner city appears to have a higher proportion of its population (over 5 years of age) who have reached at least grade 10.

However, beyond the level of grade 10 the inner city has proportionately fewer people in each category. Unfortunately the reliability of the numbers presented is somewhat questionable due to a technique called "random rounding" introduced in the 1971 census. This technique involves rounding digits to the nearest 5 or 0, and can create distortions when dealing with small population groupings such as Enumeration Areas. The technique is used to enhance confidentiality.

Income

The average incomes presented in Table 6 were calculated from the total aggregate income reported by the area residents, divided by the total number of families in the area. The average family income in the inner city is significantly below that of the city as a whole. Average incomes in McCauley West and Boyle Street are also lower than in McCauley East. These differences are consistent with the lower level of education of the inner city residents.

Housing

The inner city area has proportionately more residents living in rental accommodation than the city generally. (See Table 7). McCauley East and McCauley West, however, have significantly more owner-occupied dwellings than Boyle Street.

In keeping with this pattern of tenure, the majority of inner city residents occupy "apartments". "Apartments", according to the census definition, are buildings constructed to accommodate "suites"

TABLE 6

AVERAGE TOTAL FAMILY INCOMES, INNER CITY AND EDMONTON RESIDENTS, 1971

(in dollars)

	INNER CITY			TOTAL EDMONTON
	CT44	CT45	CT34*	
Average Family Income	7,672	6,164	6,136	10,699

*Census Tract 34 minus enumeration areas 101, 102, 052, and 053.

Source: Statistics Canada enumeration area print-outs and Statistics Canada, 1971 Census of Canada, Census Tract Bulletin, "Population and Housing Characteristics by Census Tracts, Edmonton," Catalogue 95-757.

TABLE 7

TYPE OF HOUSING, INNER CITY AND TOTAL EDMONTON, 1971

(in per cent)

TENURE	INNER CITY CT44	CT45	CT34*	TOTAL EDMONTON
Owned	23	20	13	53
Rent	77	80	87	47
TOTAL	100	100	100	100
TYPE				
Single Detached	33	22	19	60
Single Attached	2	2	3	6
Apartment	65	76	78	34
TOTAL	100	100	100	100

*Census Tract 34 minus enumeration areas 101, 102, 052, and 053.

Source: Statistics Canada enumeration area print-outs and Statistics Canada, 1971 Census of Canada, Census Tract Bulletin, "Population and Housing Characteristics by Census Tract, Edmonton," Catalogue 95-727.

or "flats", as well as a structure (i.e. "boarding house") converted to provide two dwelling units, one above the other and adjoining no other structure (this excludes a "duplex").

Most of the remaining inner city residents occupy single detached dwellings. McCauley East has significantly more single detached dwelling units, and fewer apartments, than the rest of the inner city area.

The average monthly rent in tenant-occupied dwellings was $80 in Census Tract 34, $107 in McCauley East and $63 in McCauley West. Edmonton's average rent was $124.

Table 8 provides a breakdown of the numbers of family and non-family households. There are pronounced differences within the inner city. McCauley East, like Edmonton as a whole, is predominately composed of single family households. A census family consists of a husband and wife (with or without children) or a single parent with one or more children. A family may also consist of a man or woman living with a guardianship child or ward under 21 years for whom no pay was received.

McCauley West and Boyle Street have the reverse situation, whereby the majority of residents represent non-family households. This is in keeping with the lower proportions of children and higher proportions of the elderly in these areas.

Summary

The neighbourhoods of McCauley and Boyle Street in the inner city of Edmonton, with a total population of 15,425 in 1971 constitute the study area. An analysis of census data shows the area to be different from Edmonton on a number of important demographic variables.

In McCauley and Boyle Street are found a higher proportion of males (57% cf. 45% for Edmonton) and elderly people (14% cf. 6%),

TABLE 8

HOUSEHOLDS BY TYPE, INNER CITY AND TOTAL EDMONTON, 1971

(in per cent)

TYPE OF HOUSEHOLD	INNER CITY			TOTAL EDMONTON
	CT44	CT45	CT34*	
Total Family Households	65	33	30	79
One Family/Household	63	32	29	78
Two or More Families/ Household	2	1	1	1
Total Non-Family Households	35	67	70	21
Total Households	100	100	100	100

*Census Tract 34 minus enumeration areas 101, 102, 052, and 053.

Source: Statistics Canada enumeration area printouts and Statistics Canada, 1971 Census of Canada, Census Tract Bulletin, "Population and Housing by Census Tracts, Edmonton," Catalogue 95-727.

and a lower proportion of children and young adults (26% cf. 40%).

The area has higher proportions of people of non-British origins (74% cf. 56%) and of single people (30% cf. 19%).

Average family incomes are much lower ($6,657 cf. $10,699). Average rental payments ($83 monthly cf. $124) are lower. A much higher proportion of the inner city people rent their accommodation (81% cf. 47%), and live in non-family households (57% cf. 21%) than the general Edmonton population.

In addition to these differences between the study area and Edmonton in general, major demographic differences occur within the study area, particularly between Boyle Street and McCauley East. The Boyle Street area is characterized by higher proportions of males, the elderly and single people. A higher proportion live in rental accommodation and average incomes are lower.

McCauley East is characterized by higher proportions of children and married people and therefore family households. Education levels are slightly higher as are average incomes. A higher proportion of the residents own their dwellings. McCauley West represents a mix of the characteristics of Boyle Street and McCauley East.

These marked differences between the study area and the rest of Edmonton, and within the study area, have important implications for health care. They will be discussed in subsequent chapters.

FOOTNOTES

1. L. J. D'Amore and Associates, Social Impact Study of the Stadium for the Commonwealth Games, p. 27.

2. Hugh Brody, Indians on Skid Row, pp. 3-4.

3. Edmonton, Edmonton Social Services and the Native Secretariat, The Native in Edmonton, p. 4.

CHAPTER 4

THE INNER CITY

ENVIRONMENT AND LIFESTYLES

Introduction

The health and development of the people of Edmonton's inner city are closely related to their lifestyles and to the physical and social environments within which they live. We all have "images" of the inner city, to use Anselm Strauss' term,[1] but often these images are far from accurate. Boyle Street and McCauley are stereotyped as a skid row, and an area of dilapidated houses respectively. People tend to notice the drunk panhandling outside the 102nd Avenue liquor store or note the Italian men lounging on the sidewalk outside the "Bar Italia and Billiards" in 95th Street, but are unaware of the demographic and sociological realities of the area. The press reinforces incorrect images by occasional articles on the horrors of skid row or the plight of elderly drug abusers. More balanced reporting does not make good news copy.

On closer observation, one obtains a variety of images of the inner city that more accurately hint at the wide range of lifestyles and environments packed into that one square mile of Edmonton. One is struck by the large number of expensive-looking churches -- indeed, there are many more churches in McCauley than there are bars! -- and notes that they represent a variety of ethnic traditions. "Chinatown", with its restaurants, travel agencies and stores, the Italian sector in central McCauley, and the Ukrainian cafes and delicatessans, all stand out. Posters on telegraph poles invite us to join the Spanish-speaking cultural group that meets in McCauley. One sees the drunks staggering out of the bars in Boyle Street and the groups passing wine bottles in vacant lots. The Indians are very obvious, often drunk and showing signs of injuries from recent brawls or falls. Attractive young Indian girls and white men in working clothes chat together outside the taverns, while the police cruisers patrol the streets. Off the main streets in the quieter avenues of McCauley, one can see elderly people apparently of central European origin laboriously tending their little gardens in summer, or shovelling snow in winter. In the absence of parks, children play in the streets while a public health nurse or a welfare worker pays home visits.

Raising one's eyes from the people and the streets, one is struck by incongruous multi-million dollar undertakings: the huge Commonwealth Games stadium and the light rapid transit route are both under construction, cutting through quiet residential areas. High-rise apartment blocks for the elderly tower over the southeast part of the area. These and many other images suggest incongruities that have major implications for health in the inner city area.

The authors of a well-known textbook of urban sociology have suggested that three false assumptions about inner city areas are widely held.[2] The first is that inner-city populations generally have lower socio-economic status than the populations of other parts of the city. In the case of McCauley and Boyle Street, however, this assumption is indeed correct, not false. The previous chapter shows that the people of these neighbourhoods, compared with the rest of Edmonton, have lower average family incomes, and lower levels of education. There are found higher proportions of immigrants, unemployed and people with low status occupations. They pay lower rents and live in older and lower standard housing. On the basis of these demographic variables the people of the inner city of Edmonton, do indeed have a relatively low socio-economic status.

The second common "false assumption" is that inner city neighbourhoods display a uniformity of residential areas and lifestyles. The casual observer, travelling through the area on 96th or 97th Street, could well assume this, but as has been suggested earlier, this observation certainly is false in Edmonton's situation. In the study area is a variety of residential types and lifestyles unmatched by any other part of the city of comparable size.

That low socio-economic status correlates with social disorganization is the third "false assumption". Many researchers have investigated this hypothesis in the context of other cities and have come to a variety of conclusions. Regarding Edmonton's inner city, the evidence suggests that the assumption is false: although the whole of the study area contains people of relatively low socio-economic status, social disorganization characterizes only a very small proportion of them.

These three features of Edmonton's inner city receive more attention below.

Some Definitions

The literature on the inner areas of various cities is often inconsistent in its findings, partly because different authors use particular words in different ways. Errors resulting from this can have very serious effects when it comes to implementing programmes aimed at improving inner city conditions. A word often and loosely used to refer to parts of McCauley and Boyle Street is "slum": one often hears the public and social agency personnel refer to "the slum area" or "the slum dwellers" of Edmonton. The United Nations defines a slum as "a building, group of buildings, or area characterized by overcrowding, deterioration, unsanitary conditions or absence of facilities or amenities which, because of these conditions or any of them, endanger the health, safety or morals of its inhabitants or the community."[3]

Herbert Gans uses a similar approach. To him, "slums . . . are areas in which housing and other facilities are physically and socially harmful to the inhabitants and to the larger community, primarily because of overcrowding."[4] He goes on to make the very important point that all poor areas of the city are not slums. He calls these other areas, simply, low-rent areas: "low-rent areas . . . may look equally dilapidated to the casual observer . . . but they are not overcrowded and they are not harmful."[5] Confusing these two areas, which planners and others can easily do, can have and has had disasterous results for the inhabitants.

This differentiation needs to be made in Edmonton. Most of McCauley and some of Boyle Street, especially the eastern half, is a low rent area but does not meet these criteria of a slum. The rest of the area, particularly the few blocks north and south of the C.N.R. tracks and between 95th and 101st Streets, does have many of the characteristics of a slum. The United Nations' definition of a slum is, however, identical to the widely accepted definition of "skid row", and for clarity and to facilitate comparison with other cities, the latter term will be used in this study.

The population of the inner city includes people who exhibit a wide range of lifestyles. Some authors suggest that they can be accurately classified into a number of relatively homogeneous groups. Seeley's classification is useful to us as it conforms to field observations of McCauley and Boyle Street.[6] Through living in Chicago's Back-of-the-Yards in the 1940s and later researching other inner city areas, he was struck by two major differences in inner city people: "the difference between necessity and opportunity, and the difference between permanence and change."[7] He observed these differences in both his objective research and in the people's subjective understandings. For some people, inner-city life is a necessity regardless of their wishes; for others it is an opportunity which they use. Similarly, some people feel they are permanently inner-city dwellers, whereas others consider their stay to be temporary. Table 9 shows these groups.

The permanent necessitarians, as Seeley calls them, are generally the hard-core skid row people. The "indolent" are characterized by immobility or apathy caused by disease or psychological characteristics. The "adjusted" poor do not have these overt disabilities but are resigned to a familiar slum life -- they include the elderly and other destitute or semi-destitute people unable to afford to live elsewhere. The social outcasts are chronic alcoholic destitutes, prostitutes, drug addicts and pushers, and others whose illegal or marginal behaviour excludes them from broader society.

The temporary necessitarians include the "respectable poor", people who live in the area because of the low rents but who identify

TABLE 9

TYPES AND SUBTYPES OF INNER CITY PEOPLE

LIKELIEST TERM OF INVOLVEMENT	PRIMARY REASON FOR INVOLVEMENT NECESSITY	OPPORTUNITY
Permanent	1(a) The indolent	3(a) Fugitives
	(b) The "adjusted" poor	(b) Unfindables
	(c) Social Outcasts	(c) "Models"
		(d) "Sporting Crowd"
Temporary	2(a) The respectable poor	4(a) Beginners
	(b) The "trapped"	(b) "Climbers"
		(c) "Entrepreneurs"

Source: Adapted from John R. Seeley, "The Slum: Its Nature, Use and Users", in Internal Structure of the City, ed. Larry S. Bourne (New York: O.U.P., 1971), p. 469.

themselves with the broader society and who hope to move out as soon as it becomes possible. Also in this group are the "trapped", the people who own a house in the inner city and who have not been able for financial reasons to move out as the neighbourhood deteriorated over the years. Many McCauley residents are "temporary necessitarians".

The permanent opportunists are the third type of inner-city resident: the people who choose to live there on a permanent basis. The fugitives live there to hide from the law, (though this is difficult in a small city like Edmonton), or to avoid intense business or professional competition elsewhere. Some of Boyle Street's landlords and storekeepers fit this group. The "unfindables" are people in hiding who have little social identity and are by definition usually missed by researchers and census-takers. "Models" are the rare people who see themselves as "social or religious missionaries" trying to provide a life-style model for others to follow and hence become improved. The writer has not met anyone in Edmonton's inner city who fits this group. The final group of permanent opportunists Seeley calls the "sporting crowd" (apparently an Indianapolis term). They are characterized by jollity, informality and idiosyncracies, and choose to live in the area for financial reasons and because in the inner city they can indulge their unusual behaviour. Most cities have a number of these "characters".

The final classification, the temporary opportunists, is a large and important group in the study area. It includes the "beginners", usually immigrants to the city whose meagre resources require that they first settle in the cheapest area. They provide an important labour pool for the city, and hope to save in order to move to a more affluent area. The "climbers" are similar, but have been in the city longer and are trying to accumulate enough money, skills, etc. to later move to a very much better situation: they purposely deny themselves now in the hope of considerable gains later. Finally, the "entrepreneurs" are like the "climbers" but are more ambitious and engage in business activities in the area to try to accumulate sufficient resources to move. Edmonton has people in all these "temporary opportunist" categories.

Of course, it would be wrong to place too much emphasis on Seeley's categories as being discrete groups, but they seem to apply well in Edmonton's case and are useful to refute the assumption about the homogeneity of the inner city population. People live in the area for a variety of reasons, and this variety needs to be continually considered when programmes are being designed to serve the local people.

The internal differences in the inner city, and particularly between McCauley and Boyle Street, should not, however, blind us to the most important characteristics they have in common: location and income levels. Both neighbourhoods are old areas, located close to downtown, and subject to the pressures of an expanding downtown area. Indeed, they approximate fairly closely the "zone in transition" hypothesized by the 1920s concentric zones theory of urban ecology.[8] Secondly, both are low-income/low-rent areas, and many other features correlate with this.

Closer examination will now be given to the environments and lifestyles of McCauley and Boyle Street respectively.

McCauley

The low-rent neighbourhood of McCauley contains some ten thousand people and differs from Boyle Street and Edmonton in general on a number of important demographic variables, as shown in the previous chapter. McCauley has a higher proportion of males, a very high proportion of elderly people and few children, a variety of ethnic groups with a concentration of people of non-British origins, and low levels of education and incomes.

The housing stock in McCauley is not so deteriorated as many people believe. A large number of single family dwellings and boarding houses, especially in McCauley East, are in good condition. The Edmonton Inter-Faith Society has studied this and reports that McCauley's housing stock should definitely be preserved:

> . . . 75 per cent of the housing is in good condition or in need of only minor rehabilitation and the remaining 25 per cent, while frequently needing more major rehabilitation is by no means beyond saving.[9]

McCauley is deficient in public parkland, compared both to standards set for Edmonton and for Canada as a whole. The generally accepted standard for Canadian cities is about ten acres per 1,000 people, and Edmonton is one of the few cities which has reached, and indeed, exceeded this standard, having about thirteen acres per 1,000.[10] By official Edmonton standards, McCauley is deficient over six acres of parkland per 1,000 people,[11] and this partly accounts for the number of children seen playing in the streets.

Perhaps the most important social function that McCauley serves can be seen through the concentration of ethnic minorities in the neighbourhood. In some respects it comprises what Gans calls "urban villages" -- the areas of first or second settlement for urban migrants where they "try to adapt their non-urban institutions and cultures to the urban milieu".[12] In McCauley are concentrations of people with Italian, Ukrainian, Polish, Chilean, Chinese and native backgrounds, some of whom arrived many years ago, some more recently. The area serves as a "gateway" or "port-of-entry" for Edmonton: new arrivals find the area not only inexpensive, but also culturally compatible with their backgrounds, making it easier for them to make the transition from their homelands to urban Canada. Probably no area in Edmonton at present serves this function as suitably as McCauley.[13]

The "gateway" function operates in two ways, and these are reflected in the present population composition of McCauley. For some immigrants, it has been an area to stay for a time, possibly as long as a generation, and then to move on to more affluent areas as the immigrant becomes more like the average Edmonton resident. This has been a common pattern among central European immigrants over the years. Other people, for a number of reasons, do not move on, but remain permanently in McCauley. Many of these are people who have not "made it" in urban Canada, who never accumulated the resources required to move to more expensive communities. These people are familiar to inner city field workers: they are often the lonely, isolated, deprived people found in McCauley's rooming houses and dilapidated former family dwellings. Alcohol and drug dependency is common, and they have little contact with the health care services. Many have been highly independent all their lives, and now, in advanced age, abandoned by their families, are quite isolated.

The people of McCauley have a low rate of participation in formal organizations, and this is consistent with research evidence from numerous North American cities: socio-economic class and level of participation in formal organizations are highly correlated.[14] It has been reported, however, that the atmosphere in the drop-in centres for the elderly has been changing: a lot more interaction and cooperation between the users of the centres has been reported in recent years, whereas previously people were more isolated. This beneficial change has been attributed to the outreach and other programmes of Operation Friendship.[15] The complex pattern of non-formal social organization in McCauley is discussed in Chapter 8.

Specific mention should be made at this stage of the concept of transiency as it applies in Edmonton. This matter is invariably referred to in discussions about the inner city's people. There seem to be two ideas which are often confused, but have important implications for development work and service delivery. We find first those people who are "transients" in that they come to the inner city from outside (usually from outside the city), stay for a period and then move on. In summer large numbers of young people are transient in this respect. Secondly there are the very large numbers of people who are "transients" in that they do not stay at any one address for long, but move around within the city, usually within the Boyle Street/McCauley area, or who leave the city for short periods of time and then return. Although statistics are difficult to obtain on this matter, St. Michael's School, with a school population of about 350, had a turnover of about 500 children in 1975, a rate of nearly 150 per cent. In this turnover figure, however, many children are counted more than once as they leave the school, go elsewhere for a time, and then return and re-enrol. If, instead of counting each enrollment we count each individual child only once, the turnover figure falls to something like 50 per cent.[16] This is still a high figure, but it does indicate that a large number of transients are on the move within the city, or away for only short periods of time.

Similar evidence comes from the Marian Centre, where the Director reports that more than half the men who took their noon meal there did so regularly, although their residential addresses change often.[17]

Skid Row

Skid row[18] seems to hold a fascination for many people, both the public and researchers.[19] It is a phenomenon which first appeared with the major social disorganization in the United States following the Civil War, and reached its peak in the years between the First and Second World Wars. A leading authority, Donald Bogue, has mapped the skid row areas of forty-five cities in the United States.[20] Despite at least one assertion to the contrary,[21] skid row areas are also found in most of Canada's large cities, including Edmonton. Unskilled male migratory workers, or "hobos", composed most of the skid row population in the 1920s with the opening of the west, but the manpower needs of the Second World War and the years of relative prosperity since that time have caused most of these men to be absorbed into the broader society and only a residue is left. In Edmonton most of this residue is men who are aged, alcoholic, or who are unable to work for physical or psychological reasons.[22]

The literature reveals most interesting contrasts in attitudes towards skid row as a way of life. From his experience, Seeley states that:

> No society I have lived in before or since, seemed to me to present to so many of its members so many possibilities and actualities of fulfillment of a number at least of basic human demands: for an outlet for aggressiveness, for adventure, for a sense of effectiveness, for deep feelings of belonging without undue sacrifice of uniqueness or identity, for sex satisfaction, for strong if not fierce loyalities, for a sense of independence . . .[23]

Saul Alinski grew up in the same area, Chicago's Back-of-the-Yards, at approximately the same time. He explains:

> . . . What is a slum? A slum is a dirty, miserable, diseased, human junkyard full of frustration and despair. It is a place where people exist because they do not have the means to exist elsewhere. Nobody lives there for any reason except financial pressure or the barriers of race.[24]

Bogue is more explicit:

> Instead of being a carefree, anarchistic "seventh heaven", life for the typical Skid Row resident is boring, insecure, and often lonely. Fear of robbery, worry about where the next meal is coming from, "alcoholic shakes" from need of a drink, physical discomfort, shame, despondency, and self-hate are daily feelings of these men. Instead of being proudly unfettered, the homeless man suffers perennially degraded status.[25]

Edmonton's skid row is closer to the last two descriptions than to the first.

Boyle Street has been described as "the most high class skid row in Canada" and perhaps justifiably so, as the overall social welfare system ensures that a minimum level of income and a living standard far from abject poverty is available to all those who wish to and are able to avail themselves of the existing resources. None the less, Boyle Street exhibits many of the classic destructive characteristics of skid row mentioned in the definitions quoted above. Its people have been described by one researcher who knows it well. Brody notes that skid row is a heterogeneous society:

> It is a society composed of Whites as well as Indians, more permanent residents as well as migrants. The permanent White residents are predominantly alcoholics, with a few exceptions

> among the younger men, who thrive on some aspect of petty crime or prostitution. Migrant Whites are almost entirely young men who work for a few months in the North, spending time between jobs, and money they have earned, on skid row. The Whites are predominately male, and the few exceptions are to be found among the young prostitutes. The Indian residents are all ages, most types, and both sexes: many of the older men and women are alcohol-dependent, and the younger people drink heavily. But as well as these Indian residents there are also groups of migrants, for the most part young, who have come into town for a visit or to find a job.[26]

Boyle Street meets the needs of these people in ways that no other part of Edmonton can. In Boyle Street are located many of the facilities they need: cheap residential hotels, taverns, bootleggers, cheap cafes, pawnbrokers, billiard saloons, surplus stores, day labour employers, hostels and the shelter for drunks, and of course the many welfare agencies and their arch enemies, the income tax discounters. In addition, it provides special services for people who live in other parts of the city, especially the services of cheap prostitutes and petty criminals.

The native population of skid row is very apparent: indeed, native people are more noticeable there than in any other part of the city (except possibly the bus depot). It is suggested by Brody that Edmonton's skid row serves an extremely important function for a large number of native people; for them it is the terminal point in their migration. Large numbers of native people are unable to enter the mainstream of economic life in Edmonton -- are permanently unemployed -- and are alienated from reserve or settlement. Because they are outside society's economic structures, middle class values are irrelevant to them, and an alternative community has developed in Boyle Street in which persistent drinking holds a central place. "To drink is to be part of the community, and to be part of the community is to drink".[27]

Here natives, and there were estimated to be between 700 and 1,000 of them,[28] have more to gain, in social terms, than they have to lose by drinking. Chronic alcoholism, clinically defined, is uncommon among skid row natives; they drink because it is their cultural norm, not because of physiological or psychological dependency. Chronic alcoholism is a problem of the white population of Edmonton's inner city.[29]

Nobody denies that alcoholism is a serious problem in skid row, but the common stereotype of the skid row population as merely a pool of migratory labour and chronic alcoholics is clearly incorrect. Bogue's survey research of Chicago's skid row showed that about 14 per cent of the men were complete teetotalers and a further 40 to 45 per cent were controlled drinkers. Only about one-third could be classified as alcoholic and fewer than half of these were alcoholic derelicts.[30] Although it would be wrong to attempt to transfer these findings to Edmonton, it does point to the dangers of stereotyping. In Edmonton, as in Chicago, a large number of skid row residents are not there because of alcoholism, but because of physical or mental handicap, age and poverty, or through a preference for living on handouts rather than working for a living. What they have in common is that they are poor, they are homeless, and they have acute personal problems which affect their relationships with other individuals and society at large. The helping professions have to be aware of the differences between subgroups, as well as the similarities.

Common Characteristics

From field research in the study area and the literature reviewed[31] it is possible to summarize some of the key personality and lifestyle characteristics of Edmonton's inner city people that are most relevant to health and development activities in that area. No one person will exhibit all of these characteristics, but these generalizations can be helpful in identifying the ways in which the inner city population differs from other Edmonton residents. Inner city people are characterized by:

1. Low incomes.

2. Responding best to face-to-face communications, rather than mass media communications.

3. Living by the day: they find it difficult to plan ahead.

4. Pessimism and fatalism about being able to improve their circumstances.

5. Low self images and dependency behaviour.

6. Little knowledge of what community services are available and how to use them.

7. Isolation, fear of the unknown and rejection by the broader society. For many people, this is related to language barriers. Others have had bad experiences with the broader society.

8. Few resources to fall back on in time of need, including family.

On the other hand, there are segments of the population, particularly the native people and some of the more recently arrived immigrants, who have very effective mutual support systems. This is discussed in more detail in Chapter 8.

In planning and implementing programmes with and for the inner city people, allowance must be made for the many ways in which they differ from the "average" Edmonton resident for whom most services are designed. Programmes must capitalize on the strengths of the people and make allowances for their unique characteristics.

Anticipated Changes in the Area

To complete this review of the environment and lifestyles of the inner city of Edmonton, consideration should be given to the anticipated changes in the area. The population of the study area has been falling for some time, as shown in Table 1, and it is believed that this trend has continued in the years since the 1971 census and at least in the Boyle Street area, has even accelerated.

In the City of Edmonton General Plan the Boyle Street area is seen as an extension of the downtown area and is zoned accordingly. From the community development perspective, Gans is correct in stating that the general plan concept is fallacious, as it is not relevant to the lifestyles of the people and supports mainly the "developers" and commercial interests.[32] It emphasizes "narrowly architectural goals and . . . land use and design programs for realizing them."[33]

In the 1960s, the study area was classed as an urban renewal area. The intention was to demolish most of the buildings there and build new and "better" buildings, and where appropriate to use the land for different purposes. This did not occur because of the cancellation of the programme by the Federal Government[34] when people began to realize that dispersing inner city populations does not automatically remove their personal problems, nor does it change their basic lifestyles.

The City Planning Department (which incidently does not include a social planning unit -- it is in the Social Services Department) has been working for some time on a new Downtown Plan. This is expected to include comments on the impact of the plan on the surrounding areas, including Boyle Street and McCauley.

Many people have expressed concern that the area has not been considered in the past for the Neighbourhood Improvement Program. The Planning Department has explained that Boyle Street and McCauley as well as other older communities ". . . have been specifically excluded from the study [for N.I.P.] . . . the nature and function of these areas requires a greater sensitivity to sociological programs which the neighbourhood improvement concept does not provide."[35]

There is, on the other hand, a comprehensive plan for the north-east part of the study area where the Commonwealth Games developments are taking place.[36] The City planners have had as resource material two social impact studies on this development.[37] These studies make extensive reference to the possible impact of the plan upon the Boyle Street and McCauley neighbourhoods, but unfortunately their recommendations were not accepted by Council.

Mention should also be made of the extensive changes in the so-called South-East Civic Centre area. This is the south-east corner of the current downtown area, where a considerable number of public and commercial buildings have been, or will soon be constructed. These include the new Federal Courts Buildings, the new Citadel Theatre, the Sun-Life Building and very importantly, the Cultural and Convention Centre.

It is expected that the construction of these and other buildings in the Civic Centre will have major implications for the land use patterns on its periphery including Boyle Street. Most of the Boyle Street residential sections are currently zoned R-5 Medium Density Residential District (i.e. buildings up to six storeys high), but are now being used for much lower density residential purposes. Up until now, it is believed, it has not been profitable for developers to undertake the construction of higher-density residences and new commercial undertakings in this area, but with the construction of the new Civic Centre area the situation is expected to change.

The old, inexpensive accommodation, cafes, stores, and bars which now characterize Boyle Street will probably be demolished at an accelerated rate in the near future as the downtown area pushes eastwards, and new land uses become profitable to developers.

One of the few pleasing aspects of city planning for the area has been Council's recent policy decision to encourage neighbourhood planning. In execution of this policy, it appropriated the sum of $100,000 early in 1977 for the development of a comprehensive neighbourhood plan for Boyle Street/McCauley. It is understood that the Planning Department intends to apply a community development process to the development of this plan, and to have it completed and submitted to Council by the end of November 1979.[38] Further reference is made to this matter in Chapter 8.

Population Movement

It is generally agreed by the people familiar with the inner city area, that the Boyle Street residents, who are now being displaced by commercial and other developments, are tending to move north into McCauley where there is still relatively cheap accommodation, many important social agencies, and ready access to other facilities necessary to the skid row and other inner city cultures. There has been some opposition to this movement from the long-term residents of McCauley, who consider that the Boyle Street people are undesirable and reduce the standards of their community. As there is no other location in the city, however, which meets the peculiar needs of the displaced Boyle Street people, it is expected that this trend will continue.

The Chinese community deserves special mention. It has been a stable community in the 96th Street -- Jasper Avenue -- 97th Street area for many years, but now feels the pressure to move. The Chinese people have conducted a self-survey with the aim of working with the City planners to decide how, when, and where they should re-locate.

The pressures on land use change in McCauley are not nearly as great as those in Boyle Street. Except for the commercial strips along the C.N.R. tracks, most of the area is zoned R-4 General Residential District, that is, for transition from its present R-1 single family dwellings land use to a more intensive land use and a wider range of residential accommodation, including residences up to four storeys high. There are at present few commercial pressures on McCauley to change; the major pressure is the northward movement of displaced Boyle Street residents mentioned above.

Conclusion

The demographic changes which are now taking place in the study area and which are expected to continue and even accelerate have significant implications for health services in the area. Many informants have suggested that the City has in the past adopted a policy of ignoring the Boyle Street and McCauley areas, assuming that commercial developments will sweep away the problems without the City having to confront them. The steps towards developing a neighbourhood plan for Boyle Street/McCauley will, it is hoped, reverse this situation.

Any changes to the health care services in the area will have to be accommodated to the major land use and population changes which are occurring and preferably be a component of a comprehensive planning approach to local development.

FOOTNOTES

1. Anselm L. Strauss, Images of the American City.

2. Noel P. Gist and Sylvia Fleis Fava, Urban Society, 6th. ed., pp. 273-274.

3. United Nations, Urban Land Policies, Document ST/SCA/9, p. 173, quoted in Nels Anderson, The Urban Community, p. 191.

4. Herbert J. Gans, People and Plans, p. 31.

5. Ibid.

6. John R. Seeley, "The Slum: Its Nature, Use and Users," in Internal Structure of the City, ed. Larry S. Bourne, pp. 469-474. Gans supplies another, not dissimilar classification, based on social class and life-cycle stages, He differentiates five groups: (1) the "cosmopolitans," (2) the unmarried or childless, (3) the "ethnic villagers," (4) the "deprived" and (5) the "trapped" and "downwardly mobile." Gans, People and Plans, pp. 36-39.

7. Seeley, "The Slum", p. 469.

8. Ernest W. Burgess, "The Growth of the City: An Introduction to a Research Project," in The City, by Robert E. Park, Ernest W. Burgess and Roderick D. McKenzie.

9. Edmonton Inter-Faith Society, McCauley Boyle Street Study, Summary p. 1.

10. George A. Nader, Cities of Canada, vol. 2, Profiles of Fifteen Metropolitan Centres, p. 368.

11. Edmonton, Edmonton Parks and Recreation, Edmonton Parks and Recreation Master Plan 1970-1980, pp. 27-35.

12. Herbert J. Gans, The Urban Villagers, p. 4.

13. E. D. Ted Parnell, Stadium Impact, pp. 14-16.

14. Gist and Fava, Urban Society, p. 363.

15. Alice Henbest, Operation Friendship, interview, June 1976.

16. Erica Bell, Edmonton Social Services, interview, June 1976.

17. James Guinan, interview, July 1976.

18. The terms "skid row" and "skid road" are often used synonomously in the western part of North America. "Skid road" is the older term, and was coined in Seattle where it referred to a road on the waterfront down which logs were skidded to be loaded onto ships. Loggers and other migrant workers lived nearby, and services that they required -- bars, flophouses, etc. -- developed in that area. In due course, the name was changed to "skid row" as it became used in other cities throughout North America, and as this is the more common and unambiguous term, it is employed in this study.

19. Important works in this field include Kenneth Allsop, Hard Travellin'; Nels Anderson, The Hobo; Bogue, Skid Row; Gans, Urban Villagers; Seeley, "The Slum"; Samuel E. Wallace, Skid Row as a Way of Life; and Jacqueline P. Wiseman, Stations of the Lost.

20. Bogue, Skid Row, pp. 17-45.

21. "Skid row is a phenomenon peculiar to the United States" (Wallace, Skid Row, p. 13).

22. Geoffrey E. Milligan, "Transient Men and Skid Row", pp. 9-28. Other useful histories are Allsop, Hard Travellin', and Wallace, Skid Row.

23. Seeley, "The Slum", p. 468.

24. Saul D. Alinski, Reveille for Radicals, p. 58.

25. Bogue, Skid Row, p. 116.

26. Hugh Brody, Indians on Skid Row, p. 8.

27. Ibid., p. 12.

28. Ibid., p. 3.

29. Ibid., p. 29. This has been confirmed by the staff of a number of Boyle Street social agencies, including the Single Men's Hostel Clinic and the Intoxication Recovery Centre.

30. Bogue, Skid Row, pp. 90-93.

31. See particularly Warren C. Haggstrom, "The Power of the Poor", in Mental Health of the Poor, ed. Frank Riesman, Jerome Cohen, and Arthur Pearl, pp. 206-207; and Milligan, "Transient Men", pp. 7-9.

32. Gans, People and Plans, pp. 60-62.

33. Ibid., p. vii.

34. Edmonton, Planning Department, Older Neighbourhoods in Edmonton, [July 1975], p. 36.

35. Edmonton, Planning Department, Neighbourhood Improvement, August 1974, p. 6.

36. Clarke Field Development Scheme By Law 4640.

37. L. J. D'Amore and Associates, Social Impact Study of the Stadium for the Commonwealth Games; and Parnell, Stadium Impact.

38. Edmonton, Planning Department, Boyle Street/McCauley Planning Process.

CHAPTER 5

MORBIDITY PATTERN

Introduction

Morbidity refers to the amount of disease in a population, and is notoriously difficult to measure accurately. The three main research strategies used are first, the study of records kept by doctors, hospitals, health insurance organizations, etc.; secondly, systematic, standardized clinical evaluations of a population or properly drawn sample; and thirdly, survey research in which respondents answer questions relating to their illnesses, symptoms and use of health facilities.[1] Each of these strategies has methodological problems and in fact provides different estimates of morbidity for a particular population. As discussed in Chapter 2, elements of each strategy have been employed to obtain the data which will be presented in this chapter.

It appears that the pattern of morbidity within the study area is typical of older low-rent neighbourhoods and skid row sections of large urban communities. It is generally agreed that the people of Edmonton's inner core area do not have different illnesses from the people of the rest of the city, but rather some diseases are more prevalent, and others are more apparent, even if they are not more prevalent.

Health professionals and other knowledgeable informants in the inner city show a high degree of concurrence in their views about the morbidity pattern of the area, and this corresponds fairly closely to published data from other North American cities. The main high-risk groups are children, the elderly, and the skid row population, and these will be discussed in turn.

Children

Although the population of Edmonton's inner city has a lower proportion of children than the city average, the 1971 census showed that, in the study area, 19.33 per cent of the population, or some 3,000 children, were under fifteen years of age. Most of these children are considered by health workers to be at a greater risk of suffering health problems than are children living in more affluent areas. The most important health problems of these children are:

Respiratory diseases: chronic colds and their complications, such as bronchitis

Strep. throat/scarlet fever and the accompanying cardiac complications

Whooping cough

Lice

Scabies

Impetigo

Rashes

Infected cuts and abrasions

Malnutrition: from poor diets, rather than insufficient quantities of food

Developmental retardation, including speech.

All these diseases are believed to occur more commonly in the inner city than in the rest of Edmonton. They are closely related to the lifestyle of the people: a low standard of housing, personal hygiene, medical care, diet and parenting skills is involved. The staff of the schools in the area see the results of these problems, and some have even decided that the children's health has to take priority over teaching: good health is a prerequisite for learning. Consequently, the schools now provide such services as hot meals for the children, and clothes washing facilities.

The Local Board of Health staff has an excellent programme of identifying from birth notices, new-born babies who are considered to be "at risk": and of following up these infants and their mothers to try to ensure an adequate standard of health care. The 1975 Local Board of Health figures indicate that the new-born babies "at risk" in Edmonton represent 50 per cent of all births. In the Central Region, which includes the study area, the rate was 70 per cent of all births. Presumably the rate in the study area was even higher than this.

The Elderly

It has already been mentioned in Chapter 3 that in the inner city generally, but in McCauley in particular, a high concentration of elderly people is found: the 1971 census showed that 14.39 per cent of the inner city population was over 65 years of age, a total of some 2,220 people. Over 25 per cent of the population is aged 55 years or older. The main health hazards of these people are chronic illnesses, lowered resistance to stress, and some increased anxiety over their health.[2] These common problems of the elderly are exacerbated in the inner city because of isolation, and limited contact with health and other supportive services.

A considerable degree of concern has been expressed lately about the elderly isolates who are alcohol and drug abusers, and these problems are being investigated under the Federal Non-Medical Use of Drugs Program.[3] Little is known yet about the extent of these problems in Edmonton, but some health workers consider them to constitute the major causes of ill health amongst Edmonton's inner city elderly.

The Skid Row Population

Morbidity on Edmonton's skid row is similar to the pattern found in corresponding areas across North America. Alcoholism and related diseases are very prevalent; we noted in the previous chapter that approximately one-third of Chicago's skid row men were alcoholics[4] and it has been estimated that there could be some 1,500 to 2,000 alcoholics in Edmonton's skid row.[5] The many acute problems of skid row alcoholics include blood poisoning, delirium tremens, skin problems including the effects of lice and bed bugs, and injuries from fights, assaults and falls. Chronic problems include open body sores ("wine sores"), malnutrition, liver damage, stomach ulcers, insomnia and epilepsy.

Physical handicap is very prevalent. Bogue found that "seven out of each ten men on Skid Row are physically handicapped to such an extent that they have restricted capacity to hold a job requiring normal physical exertion as laborers or semi-skilled workers".[6] In his sample, physical handicaps and alcoholism did not seem to be related.

Ear, nose and throat infections are endemic. Pneumonia is a serious problem, and is related to the people's lifestyles. In winter, almost everyone on skid row has a continual cold, and this, combined with exposure to the weather, poor diet, inadequate clothing and excessive drinking, contributes to pneumonia.

Tuberculosis is also a major public health problem of the inner city. The Local Board of Health reported that in 1975, 24 or 38.7 per cent of the 62 new tuberculosis cases for that year came from Central Region, although it contains only 14.7 per cent of the city's population.[7] The high incidence of tuberculosis there is related to people's lifestyles: the Board of Health points out that "itinerant persons and those of no fixed abode or regular occupation living in common lodging housing or welfare institutions within the inner city core are commonly victims of pulmonary tuberculosis."[8] It is very difficult to control infections among the residents of the hostels. These are environments well suited to the culture of the tuberculosis bacilli.

Alberta has a very high incidence of venereal diseases, particularly gonorrhoea. The incidence of this disease increased from 268.1 per 100,000 in 1970 to 466.9 per 100,000 in 1974[9], and although statistics are not publically available, it is assumed that this disease is very prevalent in the inner city areas.

The dental health of the people of both Boyle Street and McCauley is believed to be very poor; in fact, one field worker trained in dentistry described the area as "a dental disaster"! Dental health seems to be low in the people's priorities, both in Edmonton's inner city and elsewhere.[10]

Mental illness is also reported to be very common on Edmonton's skid row, particularly personality disorders and chronic schizophrenia. Bogue found that 20 per cent of the men he surveyed in Chicago were either psychotic or neurotic, while another 36 per cent were classed as "abberant". Only 38 per cent could be labelled "normal".[11] We have no reason to assume that the same proportions apply in Edmonton, but it is known that the community mental health nurses have very heavy caseloads in the inner city, and many chronically mentally ill people alternate between living in the inner city and the Alberta Hospital, Edmonton.

Suicide, which many consider is related to mental illness, also has a high prevalence in the inner city. A recent survey showed that, according to official statistics, the inner city of Edmonton (as well as four census tracts in other parts of the city) has a suicide rate of over 30 per 100,000 people, compared to the overall Edmonton rate of 12.9 per 100,000. Furthermore, native suicide rates in Alberta may be as much as twenty times greater than the rates for non-native people, which is even more disturbing.[12] Suicide is one of the preventable causes of death from which the inner city people suffer at a much higher rate than the general public.

Conclusion

Interviewing field workers in Boyle Street and McCauley regarding morbidity in the area inevitably led to the topic of access: the physical proximity to ill people of health services and the perceived accessibility of those services. When asked "What are the main health problems of the people of the inner city?", both professional and voluntary personnel often replied that the main problem is getting health services to people, and getting people to the health services. For many knowledgeable informents, this question of access is far more significant than the morbidity pattern itself. The question of access and perceived availability of health services will be discussed in more detail in Chapter 7.

Many of the most disabling diseases and causes of mortality on skid row, and in the inner city in general, are diseases which have been virtually eliminated elsewhere in Edmonton or at least have a lower incidence. Injuries caused by violence, malnutrition, pneumonia, tuberculosis, lice infections and scabies are all examples. Further, disease in the inner city tends to be much more disabling than it is to people of other neighbourhoods, as inner city people have fewer resources to fall back on: they are less resistant to disease, workers cannot afford to lose days off the job, and many people have no family or friends to care for them while they are sick.[13]

Disease in the inner city is a burden for the public. It involves both direct payments for the health care of the people and earnings forgone by work days lost through sickness. In addition, the inner city harbours a pool of communicable diseases (e.g. venereal diseases, tuberculosis and impetigo) which spread to other areas. Clearly then, the morbidity pattern of the inner city is a public concern, and a matter that demands public attention.

FOOTNOTES

1. David Mechanic, Medical Sociology, p. 227.

2. Edmonton, Edmonton Social Services, Social Planning Unit and The Society for the Retired and the Semi-Retired, Edmonton Services to the Elderly: 1974, p. 46.

3. Mary Lee Michael and Jim Reid, "Operation Friendship Service and Research Project On Elderly High Risk Group."

4. Donald J. Bogue, Skid Row in American Cities, pp. 90-93.

5. Maj. Ricard, Salvation Army, Edmonton, interview July 1976. This estimate seems a little too high, but no empirical data are available to confirm it.

6. Bogue, Skid Row, p. 94.

7. Edmonton, Local Board of Health, Report of the Local Board of Health 1975, p. 26.

8. Ibid., p. 24.

9. Alberta, Department of Social Services and Community Health, Report of the Task Force to Study the Problems of Venereal Disease in the Province of Alberta, p. 19.

10. Bogue, Skid Row, pp. 214-215.

11. Ibid., p. 383.

12. Alberta, Task Force on Suicides, Report of the Task Force on Suicides, pp. 281-288.

13. Bogue's statistical analysis showed that, within his Chicago sample, "illness has roughly 2.0 to 2.5 times the disabling effect on Skid Row residents that it has upon the male population generally." Skid Row, p. 203.

CHAPTER 6

COMMUNITY HEALTH RESOURCES AND THEIR UTILIZATION

Introduction

The purpose of this chapter is to provide an inventory of the community health resources for the inner city of Edmonton, and to describe and analyse the ways in which they are utilized by the people of the inner city. These data are of utmost importance to the study, as it is from this material that conclusions will be drawn as to the appropriateness of the existing services. These data will be used to investigate the relationship of social class to usage of health facilities, and the relevance of the concept of accessibility in the context of Edmonton's inner city. First comes an overview of the medical and social welfare agencies which compose the health resources for the inner city, and secondly a discussion in some detail of their utilization.

1. INVENTORY OF MEDICALLY-ORIENTATED RESOURCES

The medically-orientated health resources that serve or could serve the people of the inner city can be classified for convenience into three groups: the agencies located in the study area, those located elsewhere but whose staff operate in the area, and those agencies whose staff are available to all -- what could be called the "universal" health services.

1.1 Agencies Located Within the Area

The obvious shortage of health services in the inner city has been one of the reasons why the present study has been carried out. Three major health resources are located in the area.

1.1.1 Private Physicians. Only one private physician has his clinic located in Boyle Street or McCauley. He has his office in an old renovated house at the corner of 98th Street and 105th Avenue. This is within two blocks of the Single Men's Hostel, the Women's Emergency Accommodation Centre, the Men's Shelter, and the Marian Centre. It is therefore not surprising that a large proportion of his patients are the "skid row" type users of these agencies.

1.1.2 Single Men's Hostel Health Unit. This health unit is physically located within the Single Men's Hostel, and is administratively part of the Hostel, which is one of the institutions with the Homes and Institutions Branch of the Alberta Department of Social Services and Community Health. It is located at 10010-105A Avenue.

The Health Unit is staffed by three Registered Nurses, and is designed to serve men who are registered or eligible to register at the Hostel, women registered at the Women's Emergency Accommodation Centre on the opposite side of 105A Avenue, and men from the Men's Shelter which is located at the rear of the Hostel.

1.1.3 Salvation Army Harbour Light Centre and Rehabilitation Unit. This agency is located in Boyle Street, at 9611-102 Avenue, adjacent to the Salvation Army Men's Hostel. It is a treatment centre for men suffering from alcoholism, drug addiction, and related problems. The treatment programme is ideally twenty-eight days long, and accommodates on the average about twenty men. No medical personnel are on the staff.

1.2 Agencies Located Elsewhere But Whose Staff Work Inside the Area.

At least five health agencies are located outside the Boyle Street/McCauley area, and have staff operating within these communities.

1.2.1 The Alberta Alcoholism and Drug Abuse Commission has an experienced community worker assigned to the study area to provide a liaison between the Commission, the people and social agencies of the area.

1.2.2 The Edmonton Home Care Program, a joint operation of Edmonton Social Services and the Local Board of Health, has Social Workers and Registered Nurses making home visits in the area to assess applicants for home care services, and to consult with other agency personnel.

1.2.3 The Local Board of Health has two Public Health Nurses providing a generalized public health nursing programme in the area, promoting health by active counselling and health education in the home and schools. In addition, health screening is carried out by them in the kindergartens and schools.[1]

A specialist Geriatric Charge Nurse has also been appointed within the Public Health Nursing Division. She spends much of her time working in Boyle Street and McCauley, because of the high concentration of elderly there.

1.2.4 Mental Health Nurses of the Regional Mental Health Adult Clinic, Division of Mental Health, Alberta Department of Social Services and Community Health also work in the study area. They provide long-term follow-up for former in-patients of Alberta Hospital as well as other psychiatric patients. This is done by each nurse liaising with what is considered to be a "key" social agency in his or her own area.

1.2.5 The Victorian Order of Nurses also has one experienced nurse whose district stretches north as far as 118th Avenue in Norwood but includes patients in the inner city. Almost all her patients are over 65 years of age.

1.3 Universal Health Services

In addition to the agencies already listed, a wide range of health services is available to all the people of Edmonton; these we might call "universal" health services. The following are some of the agencies in this category that are most important for the health care of the inner city population.

1.3.1 The Alberta Health Care Insurance Commission administers the health care insurance plan (Medicare) for the residents of Alberta. Medicare by statute ensures that all persons receive adequate health care irrespective of financial circumstances.

1.3.2 The Division of Social Hygiene of the Alberta Department of Social Services and Community Health provides free clinics for the diagnosis and treatment of venereal diseases, educational resource material on venereal diseases, and traces contacts. Its clinic is located on the west side of the downtown area, at 100th Avenue and 107th Street.

1.3.3 The Intoxication Recovery Centre is an activity of the Alberta Alcoholism and Drug Abuse Commission. It has a seven-day non-medical residential programme for up to thirty persons who indicate a desire to do something about their addiction to alcohol and/or drugs. This facility is located at the north-west corner of the downtown area, at 103rd Avenue and 107th Street.

1.3.4 The Local Board of Health has a variety of services available to the whole community in addition to those mentioned as operating directly in Boyle Street/McCauley. Of particular relevance to the people of these two neighbourhoods are the services offered at the Avord Arms Clinic in downtown Edmonton, at 10005-103A Avenue. There infant and pre-school clinics provide immunization, health supervision and developmental screening for infants, and pre-natal classes. A family planning/birth control clinic provides counselling, contraceptives and follow-up.

A Family Counselling Service is also operated by the Local Board of Health through its Mental Health Division and is based in the CN Tower. The staff provide consultation to community based agencies, and direct services to clients as far as resources permit.

1.3.5 There are, of course, many private physicians outside the study area, whose professional services are ostensibly available to all. A number of physicians' clinics are located outside, though near the borders of the study area, including: --

Royal Alexandra Place, at 101st Street and 111th Avenue,
Tegler Building, downtown at 101st Street and 102nd Avenue, and
Norwood Clinic, at 95th Street and 116th Avenue.

1.3.6 The final category of health resources available is the public hospitals. Most relevant to the inner city people are the Royal Alexandra Hospital, located just beyond the north-west corner of the study area, the University of Alberta Hospital on the south side of the city, and the Charles Camsell Hospital, west of the Royal Alexandra Hospital, at 138th Street and 115th Avenue. These are all general hospitals and have twenty-four hour emergency departments. In addition the Alberta Hospital, Edmonton, located some miles to the northeast of the city, provides important psychiatric services.

2. INVENTORY OF SOCIAL WELFARE AGENCIES

The above inventory of medically-orientated health resources shows that few such services are located in the inner city. In the area, however, is found a heavy concentration of social welfare agencies, as is the case in most large cities. More than twenty social welfare agencies are located in the one square mile of Boyle Street and McCauley, and their functions cover a wide range. The appendix lists most of these agencies.

2.1 Social Agencies Located in the Area

A number of these social agencies located in the area have functions designed to meet the people's health needs. Some of these will be briefly mentioned here.

2.1.1 The Bissell Centre is one of Boyle Street's oldest and best known agencies. It is centrally located in 103A Avenue at 96th Street. It has a wide range of programmes including two senior citizens drop-in centres, one of which provides lunch to the elderly each weekday under the auspices of Operation Friendship. The Local Board of Health is able to make effective use of these programmes for the elderly. Direct emergency aid is available and two social workers plus the Director are in close touch with the people and make many referrals to health services. A short-term (four hour) child-minding service for mothers to attend appointments, etc., is also provided.

2.1.2 Boyle Street Community Services Co-operative Ltd., or as it is better known, the Boyle Street Co-operative, is located on 96th Street opposite the Bissell Centre. It also is a very well known agency, and operates a wide range of programmes. Perhaps the most important in the health context is its role as a contact point between the professional health services and the people of Boyle Street. Its clientele are largely the "skid row" types and natives, rather than a cross section of the community.

Prior to April 1975 a Public Health Nurse held a clinic at the Co-op each working day, but this service was terminated with the agreement of both parties as it was felt to be not meeting people's needs. Like the Bissell Centre and Operation Friendship, the Co-op stresses the importance of outreach programmes rather than traditional agency-based ones.

2.1.3 The Marian Centre in Western McCauley (10528-98th Street) is in the area where a number of agencies are concentrated, viz. the men's and women's hostels, the men's shelter, and the local physician's clinic. The Marian Centre is an operation of the Madonna House movement, a lay movement which provides the facilities and staff, and raises funds from its supporters throughout the Province. Most of its clients are men, the majority residents of the Single Men's Hostel and the Men's Shelter. A variety of welfare services is available to them. Anybody is welcome irrespective of physical condition, or if intoxicated or under the influence of drugs. Until recently, when the Single Men's Hostel took over this function, the Centre provided a midday meal for over 300 people daily.

2.1.4 Operation Friendship at 10631-96th Street with its two drop-in centres for the elderly, where lunch is provided Monday to Friday, and its policy of stressing the outreach approach to service delivery, has already been mentioned. The staff work closely with the Geriatric Charge Nurse.

Accommodation is closely related to health. Four agencies provide temporary accommodation to the transient and skid row population of the study area. These are:

2.1.5 The Men's Shelter which is run by the United Church and provides basic overnight accommodation for men who cannot get into the Single Men's Hostel, usually because they are intoxicated. It can accommodate about 120 men, and is located at 10010-106 Avenue.

2.1.6 The Single Men's Hostel, an operation of the Alberta Department of Social Services and Community Health, provides high standard accommodation and meals for about 370 men (including in its overflow facilities), aged 18 to 60 years. It is located behind the Shelter, in 105A Avenue. Accommodation is meant to be temporary, with a seven-day review, and is not available to men who are under the influence of alcohol and/or drugs. As mentioned above, the Hostel has a clinic staffed by three nurses.

2.1.7 The Women's Emergency Accommodation Centre is operated by the United Church on a similar basis to the Single Men's Hostel, and is located on the opposite side of 105A Avenue from the Men's Hostel. The women take their meals at the Hostel and have access to its clinic.

2.1.8 The Salvation Army Hostel at 9611-102 Avenue is located in Boyle Street proper, rather than in the south-west corner of McCauley, where the preceding three hostels are found. It is part of the Salvation Army Men's Social Service Centre, and provides accommodation and meals at low charge to its residents, as well as other services. No restrictions are placed on the length of stay.

2.2 Social Agencies Located Elsewhere But Whose Staff Work Inside the Area

As in the case of the medical care services, a number of social agencies which are located outside the study area have staff who work inside it. Two such agencies will be mentioned as their activities are closely related to those of the medical care services.

2.2.1 Meals-on-Wheels which operates through the Victorian Order of Nurses, has a team of volunteers available to deliver low-cost hot noon meals, Monday to Friday, to those unable to prepare meals for themselves.

2.2.2 The North Edmonton Regional Office of the Alberta Department of Social Services and Community Health, located in 82nd Street near 117th Avenue to the north of the study area, is well known for its public assistance services, particularly financial assistance. It is said that "approximately 25 per cent of (its) welfare caseload . . . is in Boyle Street".[2]

USAGE OF HEALTH RESOURCES

An overview of health resources has been given. In this section, the pattern of usage of these resources will be examined. For convenience, they will be discussed under four headings: the Local Board of Health, private physicians, hospitals, and others.

Local Board of Health

The programmes of the Local Board of Health of the City of Edmonton cover a wide field, and are organized in a divisional structure. The divisions are: --

Administration

Medical

Nursing

Mental Health

Dental Health

- Home Care (jointly with Edmonton Social Services)

Environmental Health

Special Services (including nutrition, health education, etc.).

In addition, the city is administratively divided into eight health regions. Each region includes a regional office, in which most of the divisions are represented. The Central Region which includes the Boyle Street/McCauley neighbourhoods has a population of 66,207 or 14.66 per cent of the city's population (May 1975 figures), and covers an area of about eight square miles (20 square kilometres). Its boundaries are the CNR tracks at 126 Avenue and the Municipal Airport in the north, 125th Street in the west, the river in the south and 82nd Street, 112 Avenue and 90th Street in the east. (See Map 3.)

The regional clinic is located downtown in the Avord Arms Building. Eight district public health nurses, including one for each of the McCauley and Boyle Street districts work in the region, sharing their time between their districts and clinic duties.

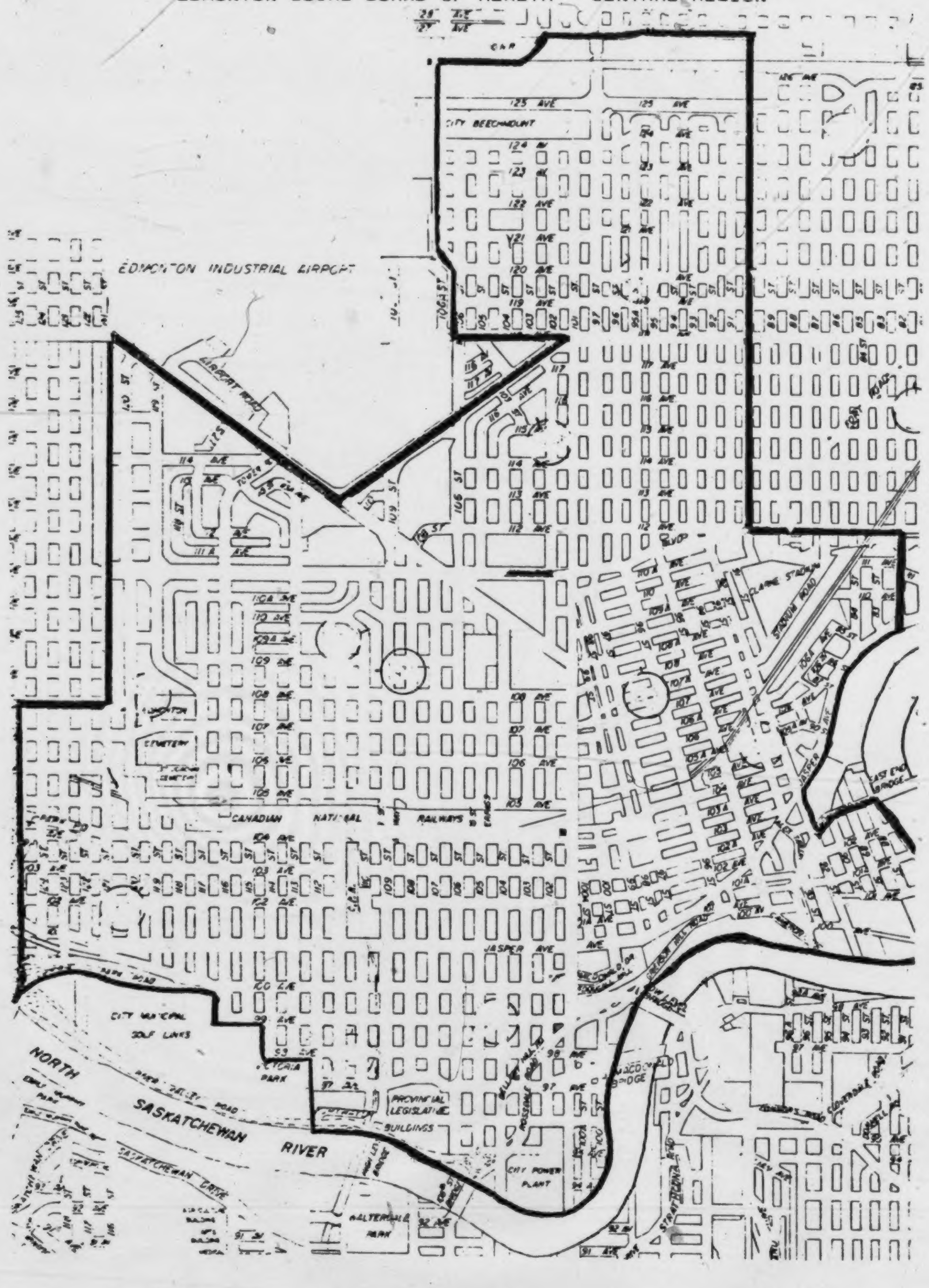
The Local Board of Health's functions are oriented towards preventive public health. The provision of individual treatment services is precluded by statute. This statutory restriction is reflected in the duties of the staff who serve the inner city area.

Public Health Nursing

One Public Health Nurse is assigned to each of the two neighbourhoods that are the subject of this study. They, as well as their

MAP 3

EDMONTON LOCAL BOARD OF HEALTH - CENTRAL REGION


125 AVE
CITY BEECHMOUNT
124 AVE
123 AVE
122 AVE
121 AVE
120 AVE
119 AVE
EDMONTON INDUSTRIAL AIRPORT
AIRPORT ROAD
117 AVE
116 AVE
115 AVE
114 AVE
113 AVE
112 AVE
111 AVE
110 AVE
109 AVE
108 AVE
107 AVE
106 AVE
105 AVE
CEMETERY
CANADIAN NATIONAL RAILWAYS
104 AVE
103 AVE
102 AVE
JASPER AVE
100 AVE
99 AVE
98 AVE
97 AVE
CLARKE STADIUM
STADIUM ROAD
EAST END BRIDGE
CITY MUNICIPAL GOLF LINKS
VICTORIA PARK
RIVER VALLEY ROAD
NORTH SASKATCHEWAN RIVER
SASKATCHEWAN DRIVE
PROVINCIAL LEGISLATURE BUILDINGS
CITY POWER PLANT
WALTERDALE PARK
STRATHCONA ROAD
CLOVERDALE ROAD

supervisor, are dedicated and competent professionals. The duties of the district nurses are described in the Board's annual report:

> [The nurses work] directly with families and individuals in the community delivering personal service in a generalized public health program. Health promotion by active counselling and health education is offered to infants, preschoolers, school children and adults in homes, clinics and community groups.[3]

The nurses are in direct contact with the inner city residents at four points: in the homes, the schools, the day care centres, and at the Avord Arms clinic. In addition, they are in contact with the staff of the other health and social agencies which serve the area.

Their time is distributed roughly as follows:

40 per cent	schools and day care centres
30 per cent	home visits
20 per cent	clinic duties
10 per cent	other duties, including staff meetings.

The Well Baby Clinic at the Avord Arms regional clinic provides counselling for parents, and routine immunization for the pre-school age group. Each infant is given a physical examination by a nurse at the first visit to the clinic and a follow-up plan is worked out. Ideally, check-ups and developmental screening are carried out at ages four months, six months, twelve months and three years.

The clinic is open every afternoon, Monday to Friday, under a no-appointment, drop-in system, and one evening per week on an appointment basis for working parents. It is felt that most of the babies seen come from the Central Region, because of the convenient location of the clinic.

The follow-up service is excellent. All the birth notices for new babies whose parents live in the region are seen by the Well Baby

Clinic Charge Nurse, and from these the infants are assessed as being "at risk" or not. A home visit is made to each "at risk" and first born infant.

If new babies are not brought in to the clinic by the time they are four months old, their parents are contacted by telephone or letter and urged to attend the clinic. If they still do not come in within the next month, the district nurse visits them at home. Most new babies are eventually seen for immunization and screening.

The above procedure applies to the region as a whole, but a recent Board of Health study indicated that some 70 per cent of infants in the region are classified as "at risk", and presumably the percentage is even higher for the Boyle Street/McCauley areas. Accordingly, all new born babies in the central area are visited as if they were "at risk".

Referrals to the inner city Public Health Nurses come from many sources, particularly the hospitals and the regional clinic itself. They refer patients to private physicians, the Family Practice Clinic at the Royal Alexandra Hospital, and to that hospital's Emergency Department. The nurses are particularly concerned at the difficulty of getting private physicians to make home visits (even the Family Practice Clinic physicians generally do not make home visits). The nurses often have to refer patients to the Royal Alexandra Hospital Emergency Department even though they feel such patients could be better served by a home visit from a private physician.

The inner city residents receive a high standard of health care from the Public Health Nursing staff. A difficulty is in their restricted range of professional responsibilities. Most of the nurses have either a degree or post-graduate training in public health nursing, and so are competent to carry out most aspects of the treatment for the health problems they encounter. They are, however, prohibited from undertaking any such treatment, and this they find personally frustrating. Their duties are restricted to screening, counselling, and referring the patient.

This is not only the nurse's problem: it is also a difficulty for the patient. One of the reasons that the nurses no longer hold clinics at the Boyle Street Co-operative is that the patients came there expecting the nurses to treat their health problems, not merely to screen them and refer them to someone else. The inner city people in particular find it very inconvenient, and impossible to understand, to be seen by a professional health worker but to receive no treatment from her.

Family Planning Clinic

Family Planning Clinics serving the whole of the city are held at the Avord Arms Building. They are administratively separate from the activities of the Central Region Clinic. Patients are seen on an appointment basis on three mornings and one evening per week. The professional staff in attendance are a consulting gynaecologist, Local Board of Health physician, Public Health Nurse, a volunteer nurse, and the Charge Nurse.

Since the clinic started operation in 1969, attendance has increased by about 20 per cent per year. Over 2,000 patients were seen in 1975: some 34 per cent were new patients, and 66 per cent were follow-up appointments. Approximately 70 per cent of the patients were self-referred, or came on the recommendation of another patient, and some 60 per cent were in the under 20 years age group. Most patients seek birth control, rather than the broader service of family planning. Oral contraception was the most popular method, with 70 per cent of the patients receiving prescriptions.

The service preserves confidentiality, and is free. Contraceptives are supplied free of charge to people who cannot afford them. A prescription is given to patients who can afford to make their own purchases. A system of recall is in operation to provide follow-up services on women prescribed oral contraceptives or fitted with an intrauterine contraceptive device. In addition, patients are regularly referred to other services where appropriate, including their family physicians and specialists, the venereal diseases clinic, and the Local Board of Health's Family Counselling Service.

As a matter of policy, the clinic does not provide any outreach activities, nor does it advertise its services. This is in contrast, for example, to the Division of Social Hygiene with its venereal diseases advertisements in the public buses. The outreach educational work that is done in Edmonton is left to the Planned Parenthood Association, a voluntary body.

The Family Planning Clinic provides an excellent service to the people who use it, but it works under severe restrictions. Its physical facilities are quite inadequate, its hours are limited and drop-in patients cannot be conveniently handled. A great need exists for an outreach programme including education in the schools,[4] and for the service to be provided in other locations besides the Avord Arms clinic.

Although statistics are not available, it seems that the clinic serves mostly middle class people. Presumably people of the higher socio-economic classes use the services of their private physicians, but those in less affluent circumstances, including the poor of the inner city, receive no regular birth control services. It is noted that many transients use the clinic to obtain free contraceptives, but permanent inner city residents do not.

The native women of the city, many of whom live in the Central Region, rarely use the clinic. Those who attend once, rarely come back for follow-up supervision. It appears that the clinic, as it is now operated, does not meet the needs of these people.

Here is an example of a programme set up to serve the needs of the city as a whole, which cannot adequately serve the peculiar needs of the inner city residents.

Geriatric Charge Nurse

The Local Board of Health employs one specialist geriatrics nurse based at the Avord Arms clinic. Because of the heavy concentration of needy elderly in the inner city, most of her time is spent working in the study area.

Her general aim is to keep people at home and independent. This is done through home visits, visiting the drop-in centres, and having close liaison with the other social agencies working in the field of geriatrics, especially Operation Friendship and The Society for the Retired and Semi-Retired.

Home visits are made to assess people believed to be in need of health care, to offer them help and support, and to refer them to appropriate services. On her visits to the drop-in centres she carries out health education, screening and referrals.

The sources of referrals to the Geriatric Charge Nurse are Operation Friendship (42 per cent), other Local Board of Health Staff (17 per cent), hospitals (9 per cent), The Society for the Retired and Semi-Retired (6 per cent), private physicians (1.5 per cent), and others (24.5 per cent). These are the 1975 figures. It is pleasing to note that landlords are now referring an increasing number of their sick elderly tenants to the nurse and other agencies in the area, a trend which complements the outreach activities of the agencies. It is disturbing, however, to note what little use is being made by the hospitals of her services, particularly considering the large number of elderly who, having no private physician of their own, could benefit from follow-up treatment and maintenance programmes under the supervision of the Geriatric Charge Nurse.

The referrals made by the geriatric nurse are predominantly to private physicians (44 per cent). Local Board of Health physicians (11 per cent), Victorian Order of Nurses, Meals on Wheels and the commercial nursing services (10 per cent), Operation Friendship (9 per cent), Edmonton Home Care Program (7 per cent), hospitals (6 per cent), and elsewhere (13 per cent), constitute the remaining referrals. (1975 figures.)

Interviews with agency staff indicate that the Geratric Charge Nurse is well liked and respected in the inner city, and provides a very useful service. Unfortunately, since there is only one nurse carrying out this work, the number of elderly reached by her is severely limited. She has excellent relationships with the social agencies involved in geriatric work, and wisely coordinates her activities with them. The Local Board of Health, through its Geriatric Charge Nurse, has made a start in the important field of services to the elderly, but one nurse alone cannot be expected to make a major impact on the area. The voluntary agencies are still left with the main responsibility for comprehensive services to the elderly.

Family Counselling Service

A family counselling service is offered through the Local Board of Health's Mental Health Division. The Division has only a small staff, and emphasizes preventive mental health activities such as professional development and consultation with agencies.

Direct counselling services are provided to families who desire help in coping with natural family crises, and who wish to improve family relationships. This again is preventive in nature, and the service is not intended to treat the severely mentally ill.

Inner city people can be referred to the Family Counselling Service by the district Public Health Nurse, the Family Planning Clinic staff, or by social workers from Edmonton Social Services. The service is not often used by the inner city people, however, as the types of mental health problems which characterize this type of area -- psychoses and personality disorders -- cannot be readily treated by the family counselling approach. Professional development activities and consultation are probably more appropriate in this instance.

Edmonton Home Care Program

The Edmonton Home Care Program (E.H.C.P.) is a joint activity of the Local Board of Health and of Preventive Social Services. It commenced operation in 1974 and the number of persons on the programme has been steadily increasing since then.

The overall aim of the programme is to provide for the care of people in their own homes, so as to prevent or delay institutionalization. This is based on the assumption that, "given certain essential conditions, the environment of home and family is particularly beneficial for the treatment, care, and support of certain individuals in our community".[5]

Eligibility criteria are stated as follows:

> In order to qualify for this Program it is necessary that a house service (i.e. nursing, orderly, physiotherapy, homemaker, home help) be required which can be shown to be capable of preventing the need for facility care.[6]

In addition to these five basic services, auxilliary services are available to eligible persons. These include:

nutrition consultation
laboratory services
supplies and equipment
transportation
drugs and dressings (on hospital discharge).

The programme can also arrange from community agencies such services as:

"Meals on Wheels"
friendly visiting
library services for the homebound
occupational therapy.

The majority of the people in the programme are elderly (some 80 per cent are over 60 years of age), and over two-thirds are women. In July 1976, E.H.C.P. was serving over 400 persons in Edmonton, and in the 1975 calendar year served a total of 1,076 persons.

The E.H.C.P. staff do not provide services directly to the participants; rather, the services are purchased by the Program from existing community resources. Most of the funds are provided by the two sponsoring agencies ($422,488 in 1975), with a small proportion ($15,265 in 1975) coming from user fees-for-service. Fees are levied on an ability-to-pay basis, and no-one is refused services because of inability to pay.

Referrals are accepted from any source, though the majority come from the hospitals and other health care agencies. Self and family referrals were only 17 per cent of all referrals in 1975.

Participants in the E.H.C.P. are to be found throughout the city, but there are few participants in the Boyle Street/McCauley area. Of the 404 participants in July 1976, only six came from Boyle Street and ten from McCauley. When we recall that most of the Program's participants are elderly, and that there is a heavy concentration of the elderly in the study area, it becomes clear that the inner city residents are under-represented among the Program's clientele. The heaviest single concentration of participants seems to be in the Oliver area to the immediate west of the downtown commercial centre, west to 124th Street.

A number of informants have suggested that the reason for the underutilization of the Program by the inner city residents lies in the nature of the Program. It is best equipped to serve middle class people who have a degree of family support, in their own homes. It cannot conveniently serve the low income, isolated, and rooming house dwelling elderly of the inner city.

A number of examples of this middle-class orientation of the Program can be cited. One is that the minimum unit of home help that the Program purchases for participants is a three or four hour service, far longer than is required for the housekeeping tasks of an elderly person in a rooming house.

Another is that the cleaning equipment used by home help personnel (brooms, antiseptic, etc.) should be provided by the participants. These items are not present in the homes of many of the inner city residents who are most in need of help. (It is noted, however, that this problem has been recognized and is receiving attention.)

In addition, many home care staff are not willing to work in the inner city because of real or imagined characteristics of the area such as physical danger to themselves, and the extreme dirtiness of some residences. Local persons working for companies contracted by the Home Care Program would probably not have these concerns. Unfortunately such people are not generally found working in this type of employment.

Another important reason for the small number of inner city participants in the E.H.C.P. is that people who receive financial assistance from the Alberta Department of Social Services and Community Health (S.S. and C.H.) are automatically ineligible for the Program's services. This includes the large number of elderly who receive pension supplements from that department.

The staff of the North Edmonton Regional Office of S.S. and C.H. advise that when one of their caseworkers becomes aware that a client needs some form of home care, and a medical certificate to this effect has been obtained, provision of the service is arranged directly with the appropriate agency or company. The department itself pays for the service.

This arrangement may appear satisfactory, but has two major drawbacks. First, the S.S. and C.H. financial assistance staff have extremely heavy case-loads so have only limited time to investigate the needs of individual clients and to follow up such things as home care.

Secondly, all E.H.C.P. participants are assessed thoroughly by a social worker/public health nurse team. This type of intensive, specialist, professional assessment and follow-up is not available to the S.S. and C.H. clients.

The psycho-social characteristics of many of the inner city elderly, already discussed, help to explain their underutilization of the home care programme. The E.H.C.P. is not accessible to them because of their lack of knowledge of community resources, their lack of contact with the helping professions, their social isolation, and their lack of trust and understanding of the broader society.

Other inner city elderly do not want the service: they are too independent, or alternatively, they look after each other and are hesitant to turn to social agencies for assistance.

Private Physicians

Health care in Edmonton, as in Canada generally, is strongly physician-centred. It is clear that the physician's role has been changing, with a reducing emphasis on the role of the general practitioner/family physician, and an increasing emphasis on the role of specialists and hospital care.[7]

Universal prepaid health insurance has been introduced to ensure that no Canadian is denied health care because of its cost, and so in theory, everyone should have equal access to the health services.

However, this has not worked out in practice, and only one physician has his clinic in the Boyle Street/McCauley area.

A considerable number of physicians and surgeons have their clinics a short distance from the inner core communities, including:

Baker Clinic	10025 - 106 Street
Birks Building	10113 - 104 Street
Links Associate Clinic	10951 - 124 Street
Medical Arts Building	11010 Jasper Avenue
Medical Dental Building	10603 - 100 Avenue
Norwood Clinic	11666 - 95 Street
Professional Building	10830 Jasper Avenue
Royal Alexandra Place	11112 - 101 Street
Tegler Building	10189 - 101 Street.

The physical proximity of these clinics to the inner city areas, however, does not ensure that the inner city residents obtain adequate health care from them.

The pattern of doctor usage seems to vary among the different groups of people in the study area. It is understood that most of the mothers of young children and a large proportion of the people who receive Provincial financial assistance, have their own doctor, as many of the latter require a doctor's certificate to prove their eligibility for assistance.

Many residents from the non-English speaking groups have their own physicians, notably the Italian, Portugese and Chinese communities. These groups use the services of doctors of similar cultural origins and who have a facility with the language.

Two large strata of the inner city society, however, tend not to use private physicians. These are the elderly and the skid row and transient populations.

The people who work closely with the elderly, especially in McCauley, feel that "most" -- at any rate over half -- of this group do not have their own physician. It is felt that most physicians are not interested in the "care" of elderly people, but are "cure" oriented. Doctors are not able to spend with the elderly the long periods of time required, and so impress them as being abrupt and uncaring. Many physicians are uninterested in the relatively minor, chronic health problems of the elderly, with no clear cut end-point to treatment.

This appears to be very different from the city as a whole. The 1973 study of senior citizens' health care in Edmonton found that "78.7 per cent [of the elderly surveyed] report having a family doctor they can contact if the need arises. Of the remaining group, one-half rely on specialists only and one-quarter feel they are not (ever) sick enough to require a family doctor. Only 1.5 per cent report not being able to find a family doctor (g.p.)".[8] Once again the inner city elderly exhibit a different pattern of usage of the health services from that of the people of the rest of Edmonton.

The second group which is inadequately served by the present pattern of private physician services is the skid row and transient group. It is generally agreed that these people do not go out of their area to seek medical attention. If they feel the need for a doctor's services they see the one doctor in the district, or go to the Emergency Department of the Royal Alexandra Hospital, or in the case of native people, often to the Charles Camsell Hospital.

Their lifestyle is such that they are unable to use the other doctors' services because they perceive such services as a reflection of middle class values and attitudes. Doctors are not willing to see and treat people who are drunk, or dirty.

Inner city people appear unable to use the appointment system almost universally adopted by private physicians: a skid row person often does not know the day of the week, let alone the time of the day. One key psychological characteristic of the skid row residents is that they live for the present, and cannot plan for the future. If a doctor's services are not available when needed, then no treatment is obtained.

The skid row people feel inadequate and lost outside their own area. To go "outside" to attend a clinic makes them feel shy, ashamed of their appearance and speech. They feel the doctor does not care, and looks down on them because it is apparent they are on welfare.

One characteristic of the inner city is that it provides temporary accommodation for needy out-of-towners. Transients stay with friends, and in the hostels and inexpensive hotels in the area. This large group of people have no private physician in Edmonton. They use the local doctor's office or hospital emergency departments when they require medical attention.

Some empirical evidence supporting the view that the people of Boyle Street and McCauley do not use private physicians to the same degree as others in Edmonton comes from the records of the Emergency Department of the Royal Alexandra Hospital. These records suggest that more than two-thirds of the Emergency patients from outside the study area can name their private physicians, but fewer than one-half of the patients from the study area can do so.

Discussion of the pattern of usage of private physicians would not be complete without further mention of the role of the only doctor practising in the inner core of Edmonton. This doctor is willing to accept all patients. His method of practice is appropriate to the needs of the inner city. He does not insist on appointments: patients can drop in to his clinic any weekday morning and be seen then. His clinic is strategically located near the hostels, and so it is not surprising that he receives many patients from the skid row community. In contrast to many other professionals, his attitude is one of accepting people for what they are, but he still stresses the need to rehabilitate people and to return them to the work force.

A remarkable degree of empathy appears to have developed between this doctor and the patients he sees. They are not reticent about bringing their problems to him.

Finally, and very importantly, he makes house calls in the area, something few other doctors are willing to do. This is a particularly important part of health care in the inner city because of the high incidence of isolated, bed-ridden sick people, chronic alcoholics, severe psychotics/neurotics and others demanding medical attention in the home.

Hospitals

The pattern of usage of public hospitals by the inner city residents is a matter of concern to both hospital administrators and to those involved in health care work in the inner city. The hospital most utilized by residents of this area is the Royal Alexandra Hospital (R.A.H.) located at the north west corner of the study area. Use is also made of the University of Alberta Hospital, and the Charles Camsell Hospital, but to a much lesser degree.

Concern is expressed by some hospital staff and health professionals working in the inner city about two types of users of the hospitals: the "abusers" and the "under-users".

The "Abusers"

The "abusers" are the many inner city people who use the hospitals -- especially the R.A.H. -- in an "inappropriate" manner. Very large numbers of people regularly visit the R.A.H. Emergency Department with minor and non-emergent health problems. This influx causes difficulties for the staff of that Department. It seems that these people use the Emergency Department as people in the past used the traditional Outpatient Clinics (the old "OPDs"): they drop in to the Emergency with any minor problem whenever they feel like it.

Many elderly people use a hospital in this manner, not really for medical treatment, but because of their loneliness and desire for human attention. Many elderly report to the Emergency with minor illnesses because they have no alternative source of treatment.

However, these self-referrals are not the only source of "abusers". Inner city health and social welfare professionals report that they are often forced to refer people to hospital Emergency Departments for non-emergent problems because the inner city people are unable to treat themselves at home owing to lack of knowledge and more importantly, lack of facilities. The perceived inaccessibility of private physicians (because of location, appointment system, and cultural characteristics) leaves no alternative but a hospital Emergency Department.

Although detailed statistics are not available, it is clear that inner city residents make much use of the R.A.H. Emergency Department. On a typical day, 30 or nearly 13 per cent of its patients were from the study area -- and we have noted that the study area has only 3.5 per cent of Edmonton's population. (Of course, the hospital's catchment area is larger than just the City of Edmonton.) If these people could have their non-emergent health problems attended to elsewhere, it could significantly reduce the pressures on the R.A.H. Emergency which have created a situation whereby patients frequently wait four or five hours before receiving treatment.

There is no reason to believe that it is only, or mainly, inner city residents who "abuse" the Emergency facility. A Royal Alexandra Hospital study conducted in 1975 showed that, overall, some 54.9 per cent of all patients seen in the Emergency Department presented with non-emergent health problems.[9] It has been suggested that a major cause of this mal-utilization is the current difficulty of finding doctors willing to make house calls, and the difficulty of obtaining an appointment to see a physician quickly in his office.

Different people define "emergency" differently. For many "an emergency is anything I can't treat myself", as one inner city worker put it. This definition is of course at variance with the hospitals' definition of emergency. A "misuse" of hospital facilities is the result.

The "Underusers"

Considerable concern is also expressed about the many inner city people who underuse the hospital services. The skid row residents are well known for this: skid row people are often referred to the

R.A.H. Emergency but never arrive. The reasons for this are in the characteristics of the people and of the hospitals. These people do not share the high value which the broader society places on health care and the need for early treatment of ailments; their priorities are different. Also, many skid row people have had bad experiences at the hospitals. They know that they will have a long wait in Emergency, and feel they are looked down on when they are dirty and partly intoxicated. There are reports of men who have actually been sent away from an Emergency Department, untreated, because of dress or demeanour.

The other group of "underusers" are the elderly, frightened, isolated folk. Professionals and volunteers in the geriatric field report many instances when these old people, seriously in need of medical attention, refuse to attend the hospital because they fear they will be admitted and never discharged. This, compounded by the virtual impossibility of getting physicians to make house calls in the inner city, creates a critical health problem for this age group. The Operation Friendship staff in particular have had some success in establishing relationships of trust with some elderly isolates, and bringing them into touch with health services, but much more of this type of outreach work is needed.

Social Admissions

The need for admissions to hospital for social reasons, rather than for direct medical reasons, has been stressed by many informants. Apparently, this is rarely done at present. It is said that, when social admission does occur, it is usually the case of a patient who is admitted at the request of his private physician, rather than a patient admitted through Emergency. Data are not available to assess the accuracy of this statement.

Informants suggest that social admissions of inner city people are needed because of the peculiar home conditions of many residents of the study area. Many are unable to treat themselves at home, or make use of out-patient treatment facilities, because of their lack of family support, their poor housing conditions, personal hygiene, diet, and other social conditions. However, the use of an acute general hospital bed is a most uneconomical method of responding to social as contrasted to medical need.

This is illustrated in the case of one Boyle Street alcoholic who suffered a broken shoulder. He was treated at a hospital Emergency Department, and was discharged with a wet cast. He had no home to go to, got drunk, and slept that night on the floor of the Men's Shelter. A few days later he was admitted to hospital with pneumonia and stayed in hospital for a considerable period of time. Probably this long period of in-patient care would not have been required if his social circumstances had been taken into consideration, and he had been admitted to some type of care facility for a day or two at the time he was treated for his shoulder injury. This does not appear to be an isolated case, as a number of inner city workers mentioned such incidents.

Hospital Discharges

Very little hospital discharge planning takes place at the hospitals used by residents of the inner city. This has serious implications for the quality of the health care of these people because of their social and behavioural characteristics already discussed. It is axiomatic that discharge planning should start on the day of admission to hospital, but in spite of bed utilization surveillance committees in hospitals, this is rarely done.

The hospitals generally do not have a "discharge planning staff". The social work departments can only act if a patient is specifically referred to them; they cannot seek out patients with social problems relevant to discharge arrangements.

The Victorian Order of Nurses did have a liaison nurse at the University Hospital, but she has been withdrawn for budgetary reasons. This leaves a serious gap in hospital based health care services to patients, especially those patients from the poor social circumstances of the inner city.

Other Hospital Services

To conclude this review of the pattern of usage of the hospitals, three other facilities will be mentioned.

(1) The Health Science Clinics at the University of Alberta Hospital provide a high standard of care for many patients, including a number from the inner city. When the Clinics were operated downtown prior to their transfer to the University area in 1960, many inner city residents would drop in for treatment. This is no longer possible, however, and the Clinics now operate on a referral and appointment basis. Not many inner city patients are now treated there. The Clinic's staff do work closely with the Public Health Nurses and the V.O.N. nurses though.

(2) The Royal Alexandra Hospital's Community Mental Health Service is hospital based, despite its title. It provides short term, intensive family and individual psychotherapeutic services for acute

psychiatric problems, and seems most effective. Its patients are generally working class people, however, as the kinds of chronic psychiatric illnesses and personality disorders found in the study area are not generally amenable to this treatment approach. Recent figures indicate that only about 12 per cent of their patients come from the study area.

(3) The Alberta Hospital, Edmonton, is a large active treatment hospital providing assessment, diagnosis and treatment services to mentally ill patients. It is the main psychiatric facility used by the inner city population. Earlier comments on the hospitals in general apply also to the Alberta Hospital, Edmonton. Many informants mentioned the difficulty they have in having patients admitted, and the problems that arise from inadequate discharge planning and follow-up.

Other Health Resources

Besides the Local Board of Health, private physicians and hospitals, a number of other health resources are available.

Community Mental Health Nursing

A programme of community mental health nursing is provided by the Alberta Department of Social Services and Community Health, through its Regional Mental Health Adult Clinic. Some ten nurses work in the central region -- which has the same boundaries as the Local Board of Health's central region -- although they do not have individual districts within the region. Each nurse operates by liaising with a key social agency in his or her region, with the aim of providing a consultative service as well as direct services to clients. The nurses receive referrals from Alberta Hospital and from other agencies, and help clients by providing individual and family counselling, and by making referrals. The staff have very heavy caseloads and, particularly in view of the large amount of crisis intervention work that they are called upon to do, seem to be seriously overextended. The Mental Health Adult Clinic is virtually the only agency which provides a long term follow-up service for people with psychiatric problems, but it seems to have little impact in the Boyle Street/McCauley area.

Victorian Order of Nurses

The Victorian Order of Nurses (V.O.N.) is a well-established respected health care agency, which provides nursing care to people in their own homes, and operates Meals on Wheels. A very experienced nurse operates in the inner city, covering the study area plus Norwood. She currently provides nursing care to eleven patients in the Boyle Street/McCauley area, and a similar number in Norwood. Almost all the patients are over 65 years of age.

The V.O.N. in general, and the V.O.N.'s inner city nurse in particular, are well known from years of successful activities. The V.O.N. regularly receives referrals not only from health and social agencies, but also from such community sources as landlords. Its fees are on a sliding scale, depending on a patient's ability to pay.

As was mentioned in discussion of the Edmonton Home Care Program, the V.O.N. has developed to meet the needs of the "typical" Edmonton patient, and so is not really appropriate for meeting the needs of the inner city residents. In the inner city area, the V.O.N. has a much larger ratio of population per patient than it does with the city overall, and this low level of use of its services is even more significant when one recalls that a much higher density of elderly people is found in the inner city than the city average.

Alcohol and Drug Addiction Services

A great deal of alcohol and drug abuse takes place in the inner core of Edmonton: intoxicated men and women can be seen in the streets, the vacant lots, and of course in the bars. Some inner city workers doubt that alcohol abuse is more prevalent in the area than elsewhere in the city, however, and suggest that it is only more easily seen. Regardless of the actual rate of alcohol and drug abuse, it is clearly one of the important social and health problems of the inner city, and five agencies in the area are specifically engaged in dealing with this problem.

(1) The Alberta Alcoholism and Drug Abuse Commission (A.A.D.A.C.) has one Community Worker who spends most of his time in the inner city, carrying out information and educational programmes and providing a liaison between A.A.D.A.C. and other social agencies.

(2) The Intoxication Recovery Centre (I.R.C.) is also run by the Commission. It has accommodation for thirty adults, and is considered to be an entry point into a programme of assessment, detoxification, diagnosis and rehabilitation. A charge nurse is on duty on each shift (i.e. 24 hours daily), and makes the final decisions on admissions and hospital referrals. Chemotherapy programmes are not initiated (this can be done in the hospitals), but a programme of individual and group counselling, Alcoholics Anonymous meetings, and recreation is provided. Residents can stay for up to seven days — and are encouraged to do so with a view to getting started on a

rehabilitation programme -- but the Director advises that the average length of stay is only two to four days.

Alcohol and drug abusers come to the I.R.C. by self referrals or on referral by social agencies, including the Police. All referrals, however, must be voluntary. About half of those assessed are admitted, and about half of those admitted are repeaters. It is estimated that some fifteen per cent of the patients admitted come from the Boyle Street area.[10]

The I.R.C. is very much criticized by inner city workers. They feel it should operate as a detoxification centre, that is, a place where any intoxicated person can go to sober up, be medically assessed, treated if necessary, and "dried out" if desired. They are concerned that the I.R.C. operates more as a treatment centre, and is very selective as to whom it will admit. It prefers to admit only those people who appear to be motivated to solve their addiction and enter a full treatment programme. In other words, the I.R.C. is said to specialize in the people who indicate the need to be cured, and turn away other intoxicated people in need of simple detoxification.

These arguments seem quite valid, and point to a major gap in Edmonton's services to alcohol and drug abusers, particularly the homeless inner city skid row alcoholics.

(3) The Salvation Army Harbour Light Centre and Rehabilitation Unit provides a well respected twenty-eight day programme for men suffering from alcoholism and related problems. Referrals are accepted from prisons, social agencies and the alcoholic himself. The main entrance requirement to the programme is that the men must be motivated to get better.

(4) Four-bed detoxification units are located at both the Royal Alexandra Hospital and the General Hospital, for patients who are both sick and intoxicated. They provide a medical back-up to the I.R.C., rather than a significant detoxification service for the public.

(5) Poundmaker Patrol provides direct services in the Boyle Street/McCauley area, and is said to do an excellent job in picking up intoxicated native people from the streets and bars, and giving them temporary care and/or treatment at the Poundmaker Lodge near St. Albert. A number of informants have pointed to the need for a similar service for non-natives, perhaps tied into the Intoxification Recovery Centre's activities.

Single Men's Hostel Clinic

The Department of Social Services and Community Health's Single Men's Hostel includes a clinic which is staffed by three nurses. The clinic was established in 1971 primarily to control the dispensing of medication, but it now provides a full nursing clinic service.

Eligibility for the use of the clinic is restricted to registered inmates of the Hostel, the Women's Emergency Accommodation Centre, and the Men's Shelter; it is not meant to serve the local community. The nursing staff are on duty from Monday to Friday during the day. During the evenings and weekends the Hostel staff dispense medication and make medical referrals.

The clinic has a high rate of usage. The nurses see 40 to 50 patients daily, and appear to provide a high standard of nursing care for those eligible. It includes a sick bay of eleven beds with space for overflow, which is very useful for inmates who are sick or injured.

However, the basic Hostel eligibility criteria still apply: men have to be single, sober, under 60 years of age, ambulatory, and have bowel control.

While the clinic now provides a good service, the limitations under which it operates have been criticized by a number of informants. Some have pointed to the fact that it is highly staffed by day, but closed at night and weekends when the need for its services is even greater. It has been suggested that the clinic would provide a much better service if it operated two shifts daily, but staffing problems at present seem to preclude this.

A major criticism is the lack of medical back-up for the nursing staff. The nurses do not have a medically authorized set of standing orders which could provide them with legal protection, nor do they have ready access to medical consultation or supervision within their own hierarchy. They are professionally and administratively responsible to the Hostel administration, rather than to a professional medical/nursing administration. This seems most inappropriate.

The clinic, by early treatment and close supervision of its patients, is now preventing the development of conditions that would otherwise lead to serious ill health and hospitalization. In this it provides an excellent service, though restricted in nature.

Health Care Insurance

Universal pre-paid health care is available in Alberta, through the Alberta Health Care Insurance Commission, but as is usual in the case of large cities, a significant number of Edmonton's inner city residents have no such coverage. It is estimated by the staff involved that 20 per cent of the residents of the Salvation Army Hostel and over

50 per cent of the men at the Single Men's Hostel have no health insurance coverage. Some of these people have never paid health insurance contributions.

Numerous reports have been received of doctors refusing to treat inner city patients who do not have health insurance. This can be cited as another example of an excellent health care programme which meets the needs of the population at large, but is inadequate so far as many inner city folk are concerned because of their peculiar lifestyles.

Social Agencies

To complete our consideration of the pattern of usage of health services, it is necessary to refer to a number of other social agencies active in the inner city, and to see how they and their clients relate to the health resources. Many of these agencies have staff who are in close touch with the people of the inner city, and perform the worthwhile function of referring inner city people to medical and other health resources.

Edmonton Social Services

This Department of the City of Edmonton has a Downtown Social Services Unit, based at the CN Tower, which operates in an area similar to the Central Region of the Local Board of Health. Through its many functions it has staff in contact with inner city residents, and these staff often make referrals to the health services. The Day Care staff are in contact with many mothers and children, and make referrals to the Public Health Nurses, hospitals, private physicians, and the Family Counselling Service. The Day Care Centres themselves are, of course, routinely visited by the Public Health Nurses.

North Edmonton Regional Office

This regional office of the Alberta Department of Social Services and Community Health is primarily involved in various forms of financial assistance and child welfare duties.

It receives many referrals from clients' doctors and some from Public Health Nurses, as many of its clients are in need of assistance because of health problems. The extremely heavy caseloads of the staff make close follow-up of clients virtually impossible, so any referrals generally take the form of simply advising clients where to go to obtain particular services. Mention has already been made of the fact that the clients of this agency receiving financial assistance are ineligible for the services of the Edmonton Home Care Program. The caseworkers are meant to make arrangements for home care themselves. This is good in theory, but in view of the workload of the caseworkers, it results in clients receiving a less adequate service than is available to E.H.C.P. clients.

Men's Shelter

The Men's Shelter tries to fill a gap in the services for Edmonton's destitute and derelict population, by providing overnight shelter for those not permitted to sleep at the Single Men's Hostel because they are intoxicated, aged, or have stayed at the Hostel unemployed for too long. Shelter is provided for a considerable number of men, on an average about 120 each night in summer, and 85 in winter. Some men also drop into the Shelter during the day, and receive attention from the staff. Basic first aid treatment is available, and men obviously in need of medical attention are sent to the Royal Alexandra Hospital Emergency Department, or if appropriate, to the clinic at the Single Men's Hostel. It is believed that men in need of medical treatment who are told to go to these facilities often do not go for the reasons already discussed. Health has a low priority among the derelict population.

This agency attempts to fill a need, but from a health point of view the Shelter has been described by one medically qualified informant as "a disaster". The quality of accommodation is minimal, and severe violence between the men staying at the Shelter is commonplace. The staff are not qualified to provide any systematic health screening which could help to arrest the progress of illness.

Bissell Centre

The Bissell Centre is one of the long established, well respected agencies in Boyle Street. It is in contact with a large number of Boyle Street and McCauley residents, of all races and age groups.

Many health problems come to the staff's attention through the drop-in child-minding centre and the senior citizens' drop-in centres; referrals are made to medical services. The Local Board of Health's Geriatric Charge Nurse is in close contact with the Bissell Centre and its drop-ins.

Boyle Street Community Services Co-operative Ltd.

The Boyle Street Co-op is also in close contact with a large number of Boyle Street/McCauley residents, through its drop-in and outreach programmes. Among other things it aims to provide a coupling between people in need on the one hand, and the existing agencies (such as medical facilities) on the other. This function is not yet well developed, but has considerable potential particularly as one aim is to recruit staff with backgrounds and lifestyles not too dissimilar from those of their clients.

Prior to April 1975 Public Health Nurses held clinics in the Co-op's building (as did the staff of a number of other agencies), but this programme was discontinued. At present, venereal disease control nurses of the Division of Social Hygiene (Department of Social Services and Community Health) are setting up a clinic at the Co-op.

A number of informants have mentioned that formerly the Co-op was able to serve a wide range of clientele, but it has now been virtually "taken over" by native people; other inner city residents, particularly those from the immigrant ethnic groups, are now unwilling to use the Co-op. The staff, however, feel that the large number of intoxicated persons in the vicinity is a greater deterrent than the presence of natives alone.

The Co-op staff know the area well, and its present objectives and mode of operating could be very beneficial to the people of the inner city. If its liaison role could be extended, it could enhance the effectiveness of the city's health services.

Marian Centre

The Marian Centre, as a voluntary agency, aims to provide a service which fills some of the gaps left by the publicly funded agencies. Everyone in need is accepted, regardless of condition, although most of the clients sleep at the Single Men's Hostel. No direct medical services are provided but those in need of treatment are taken to the local private practitioner's office or to the R.A.H. Emergency Department.

Operation Friendship

Operation Friendship, located in McCauley, provides an excellent service to the elderly citizens of the inner city. It runs two drop-in centres, a noon meal programme, and housing and recreation programmes.

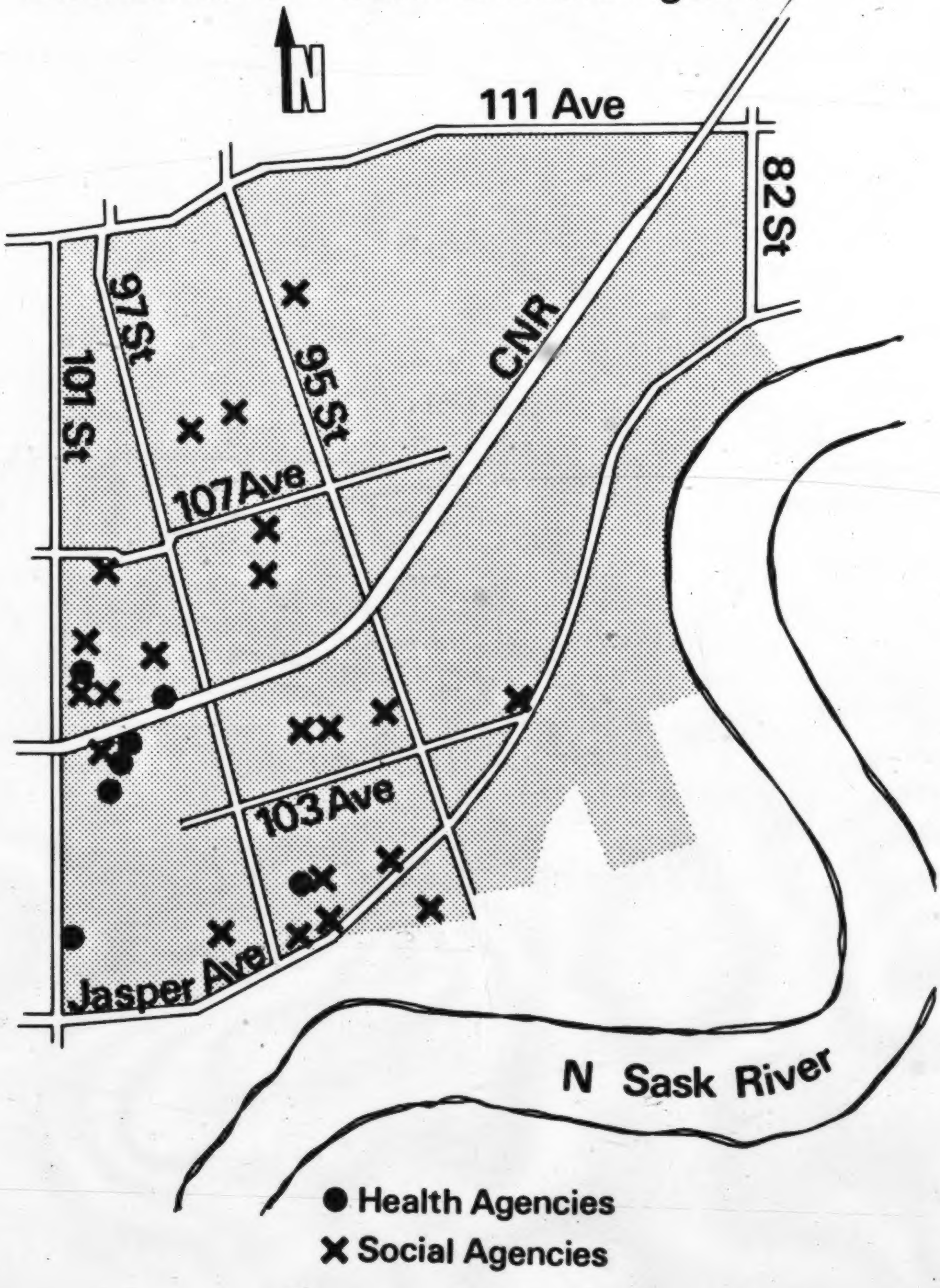
Operation Friendship is one of the agencies which recognizes the need for outreach activities, and provides this service as far as staff and other resources permit. In this way, it locates and remains in touch with many needy elderly, and facilitates their use of other agencies, including doctors and the hospitals. The staff work closely with the Geriatric Charge Nurse, and other health professionals.

Summary

A large number and a wide variety of health care services are available in Edmonton, but few are located in the inner city. In the inner city are located many social agencies among whose many functions are various health-promoting activities. In this chapter, an inventory of the relevant health care and social service agencies has been provided. Their activities in the health field have been described and discussed in some detail. The appropriateness for the inner city people of these activities is analysed in the next chapter.

MAP 4

Distribution of Health & Social Agencies


N
111 Ave
82 St
97 St
95 St
101 St
CNR
107 Ave
103 Ave
Jasper Ave
N Sask River
● Health Agencies
✕ Social Agencies

FOOTNOTES

1. Edmonton, Local Board of Health, Report of the Local Board of Health 1974, pp. 35-36.

2. Edmonton Inter-Faith Society, McCauley Boyle Street Study, p. 19.

3. Edmonton, Local Board of Health, Report 1974, p. 35.

4. On this, see Stanley Greenhill and R. Bruce Morrison, Family Planning in Alberta, 4 vols., especially vol. 4, Family Planning and the Community by R. Bruce Morrison and Marva Blackmore.

5. Edmonton Home Care Program, Report of the Edmonton Home Care Program January 1, 1975 - December 31, 1975, p. 1.

6. Ibid., p. 3.

7. Marc Lalonde, A New Perspective on the Health of Canadians, pp. 11-12, 28-30.

8. Earle L. Snider, Health Care and the Non-Institutionalized Senior Citizen in Edmonton, pp. 125-136.

9. Unpublished study.

10. Clifford A. Pope, Director, Intoxication Recovery Centre, interview, June 1976.

CHAPTER 7

APPROPRIATENESS OF THE HEALTH RESOURCES

The previous chapter described the activities of the many health and social agencies which could serve the inner city people, and analysed agency by agency the utilization patterns. The purpose of this chapter, which is based on those data, is to draw generalizations about the availability and appropriateness of the services for the inner city people, and to identify gaps in these services.

A considerable number of agencies are located in Boyle Street/ McCauley or serve the area from outside bases, and their activities cover a wide range. Although such statistics are of limited value, it may be of interest to note that the writer has counted 21 agencies in the study area, which has a population of 15,425 people (1971 census) -- a ratio of one agency to 735 people. This could be compared to the City of Edmonton for which the AID Directory[1] lists some 600 agencies serving the half-million people of Edmonton -- a ratio of one agency to 833 people. It is clear that there is no shortage of health and related services within a reasonable distance of the Boyle Street/McCauley area. Indeed, services are concentrated in and near this area to a degree not seen elsewhere in Edmonton. A number of informants have correctly pointed out that the city has several areas, including the new outlying suburbs, which are seriously deficient in these types of services.

Despite the apparent availability of services to the inner city residents, however, it is the general consensus of the people who live and work in the area that these services do not meet the people's needs. As the Inner City Field Workers Group put it, "the services available are either inadequate or inappropriate for the people who need them the most."[2]

APPROPRIATENESS OF EXISTING SERVICES

In evaluating the appropriateness of the existing services, professional and voluntary personnel usually take one of two approaches. Many state that, if the inner city people need health care badly enough, they will seek it out. The services are available somewhere in the city. It is up to the people who want help to go to existing facilities. The fact that they do not use the facilities simply indicates that they do not want health care, and so no further action need be taken by those interested in the delivery of health care.

This argument is based on a lack of understanding of the social and psychological characteristics of the people.

The alternative argument is the one that has been indicated earlier, and is one of the main conclusions of this study: services which, in their content and methods of delivery, are designed to meet the needs of the "typical" Edmonton resident, cannot be expected to meet the "atypical" needs of many of Edmonton's inner city population. Services have been designed, and also have evolved to meet the needs of the general public. Few, if any, health services have been designed specifically for inner city people.

Canada may have one of the world's best health services, but it appears to be increasingly technical, sophisticated and less human oriented. This is perhaps appropriate for the majority of a population becoming increasingly more sophisticated, but it is inappropriate for people out of this social milieu.

Access

The main health problem of the inner city then, is the perceived accessibility or non-accessibility of services. Access to health care has received much attention from researchers. This interest has recently been consolidated in a major project on the development of indices of access to medical care by Aday and Andersen.[3] Accessibility has two dimensions, depending on whose perspective is used: access can be "other defined" or "self-defined".[4] When others define the accessibility of care, they normally refer to such factors as financial costs, distance to services, or time involved. Health care is certainly accessible to inner city people when these types of criteria are used.

When health care is "self-defined", however, a quite different picture emerges: to Edmonton's inner city people, health services are perceived as being both physically and psychologically inaccessible.

Whether or not health services are physically inaccessible in the inner city may be questioned, but many inner city field workers thought so. The main bus routes in Boyle Street and McCauley run north-south, necessitating a change of buses for people travelling by public transport to such places as the clinic in the Avord Arms Building or the Royal Alexandra Hospital. Inner city people have low incomes. They cannot afford taxi fares. Elderly people and mothers with young children find it difficult to use the buses, especially when it is necessary to make transfers.

The cultural, social and psychological factors which make existing services inaccessible are probably even more important. This perceived inaccessibility comes directly from the economic and social gaps which exist between health care professionals and inner city people. Doctors and nurses tend to come from relatively well-to-do middle class backgrounds. Their professional training is highly institution-oriented. They generally have limited awareness of the social, cultural and economic factors affecting health, illness, illness behaviour and health delivery.[5]

Mechanic stresses the importance of cultural and social factors in the relationship between patients and health professionals as determinants of accessibility:

> Accessibility refers to whether or not the practitioner is perceived as responding to the person and his illness within a framework consistent with the patient's cultural expectations, the degree of stigma or social threat implied in using his services, anticipation of humiliation resulting from the treatment or from the manner in which the practitioner handles the patient, as well as other factors describing the kind of relationship that develops between practitioner and patient.[6]

Many examples from Edmonton's inner city could be given to illustrate and support this important point. A few will be mentioned.

The appointment system used by physicians in private practice effectively excludes a large percentage of inner city people whose lifestyles are not amenable to the rigid organization of time that is the norm in the broader society.

Blatant discrimination, belittling, or rejection by health professionals is a common experience of the inner city folk. Patients who are dirty, shabby, smelling of alcohol, or "on welfare" have been told by doctors' receptionists to wait outside, not in the waiting room. One young Metis woman who was working hard to "make it" in Edmonton, was recently sent to a doctor by her social worker for treatment of venereal disease. The first thing the doctor said to her was "How long have you been a prostitute?".

There are many reports of discrimination in the hospital Emergency Departments. Field workers advise that it is often difficult to get treatment for intoxicated victims of assault, the waiting periods are extremely long, and rightly or wrongly native people feel they are discriminated against. Whether or not their allegations are correct is not the point: what is important is that inner city people feel they are discriminated against by health professionals, and so are naturally reluctant to use the facilities.

Clearly then, many characteristics of Edmonton's health services result in their being perceived as inaccessible by the inner city people.

Characteristics of Health Services

In addition to the broad factors related to access, there are a number of specific characteristics of Edmonton's health facilities and health delivery systems that make them inappropriate to many people in the study area.

First, there is a strong emphasis by some in the health field on family based treatment of illnesses. A major emphasis in modern psychiatry is family therapy and community psychiatry. This approach is inappropriate to the psychiatric problems of inner city people. They often have no family and are socially isolated, so require a different approach. Doctors assume people can treat themselves at home for many illnesses and injuries, but the lifestyle of many inner city people precludes this.

Modern services tend to stress rehabilitation and a returning to work, thus reflecting the middle class values of economic selfsufficiency and the importance of contributing to society. For many inner city people this is impossible. The existing psychiatric services are effective in treating acute middle class emotional problems. Inner city people require something different. There are few services for those with incurable, chronic illnesses, psychological disturbances, non-conformist lifestyles and the elderly. Even the Intoxication Recovery Centre, as previously mentioned, prefers to treat only those whom it feels are "curable". No appropriate service is provided by this agency for the majority of the inner city's alcoholics.

Many existing services are specifically designed for middle class situations, for example, the home care programme. They are inappropriate for most of the inner city people's needs.

Services rely on self-referring, but again, this is inappropriate for many Boyle Street/McCauley people. Many of them, especially the isolated elderly and immigrants of McCauley, are afraid of health professionals. Some fear being admitted to hospital and never being discharged. Many have had bad experiences with doctors in the past. The people of skid row, in particular, have a value system which stresses survival first. "Health" has a much lower priority. There are still very few outreach services to suit the needs of these segments of our society.

Inner city health services now concentrate on prevention not treatment; Edmonton's overall health delivery system emphasizes "cure". In the inner city there are a number of agencies involved in preventive health (i.e. screening and follow-up), but it is difficult for the people to obtain diagnosis and treatment. In fact, one of the main reasons for the discontinuance of the Student Health Involvement Project

(S.H.I.P.) which operated in Boyle Street from 1969 to 1971, was that its original purpose was to provide health education, health evaluation, diagnosis and referral of patients for definitive treatment, but it entered the "cure" field and began dispensing and treating. This change in roles and functions raised a variety of legal and ethical problems. S.H.I.P. was eventually phased out after a promising start.[7]

Many inner city people, because of their limited knowledge and their distinctive lifestyles cannot be expected to treat themselves. Local health services, which by statute cannot provide treatment, are inadequate.

Edmonton's public health services concentrate on maternal and child health and communicable diseases. Little attention is given to the important public health problems of the elderly. This deficiency is particularly noticeable in the study area with its heavy concentration of elderly people.

Finally, the services of acute general hospitals are inappropriate. Admission and discharge practices are based on middle class lifestyles with no special consideration given to the needs and special problems of the inner city population.

Agency Interaction

Good relationships exist between the various agencies providing health services in Edmonton. There is no comprehensive health coordinating agency in the inner city, but most individual health workers make considerable efforts to avoid duplication of services. Some agencies report difficulty in coordinating their work with that of the Emergency Department at the Royal Alexandra Hospital. This is probably inevitable because of the characteristics of hospital emergency departments already discussed in Chapter 6.

Inner city social welfare agencies show less coordination of effort. The voluntary agencies, nevertheless, seem to have defined reasonably well their respective activities and keep in touch. There is, however, little communication with one important statutory agency -- the North Edmonton Regional Office of the Department of Social Services and Community Health. It is recognized that the heavy caseloads of the North Edmonton Regional Office staff make it difficult for them to spend time coordinating activities. None the less, this does result in lower quality services to clients.

Many of the most important health related services in the inner city are provided by voluntary agencies. There are both strengths and weaknesses in the work of voluntary agencies compared to statutory ones. A number of these agencies exhibit both chronic insecurity and anxiety over funding. These concerns certainly reduce their effectiveness.

GAPS IN HEALTH RESOURCES

The appropriateness of the health resources for the inner city has been analysed and the services found less than satisfactory. It is now necessary to identify the specific gaps.

Treatment Services

It has already been mentioned that a number of agencies are providing preventive health services in the inner city, but really none are providing active medical treatment. Respondents almost unanimously agree that there is need for more medical treatment services physically and psychologically accessible to the local people.

Chronic Alcoholics

Almost no services exist at present for those with chronic social and physiological dependence on alcohol and other drugs. Many people have stressed the need for a detoxification centre. This centre should be "maintenance" oriented, not "cure" oriented as is the Intoxication Recovery Centre at present. The aim should not be rehabilitation of all cases, but simply provision of detoxification services.

Hospital Discharge Planning

Some hospital and most field staff recognize the need for vastly improved hospital discharge planning. The present admission and discharge procedures, based on medical criteria alone, are wasteful of human and financial resources. Discharge procedures which take more account of patients' social circumstances, and which are coordinated with the services of community based agencies, could reduce costly readmissions caused by inadequate patient follow-up.

Holding Unit

Field workers and hospital personnel have stressed the need for the establishment in the Boyle Street/McCauley area of a small "holding unit". This, it is argued, would provide appropriate services for the elderly isolates and the transient and derelict inner city people who need temporary care. A few days in a holding unit could, in many cases, prevent or reduce lengthy hospitalization. It could be a place for people ready to be discharged from hospital but still unable to provide adequate self-care.

It is noted that a voluntary group is negotiating with the Provincial housing authorities with the aim of developing temporary accommodation in Boyle Street. This facility is intended to serve only aged people with no gross medical or social problems. Such temporary accommodation could be extremely useful, but would not meet the need for a professionally supervised holding unit for those of all ages who are neither independent nor mobile.

Treatment in the Home

Field workers advise that physicians almost never make house calls in the inner city. While it is recognized that this form of medical care is virtually a thing of the past in Edmonton as elsewhere, none the less a special need for it exists in the inner city. In this area are concentrated large numbers of relatively isolated, fearful, bed-ridden people without friends or family to take them to a doctor or to hospital. Perhaps more practitioners could be effectively employed in this primary care role.

Housebound Addicts

Interest has recently been expressed in the problems of alcohol and drug abusers confined to their homes. This is thought to be particularly serious among the elderly in the inner city. A recent study funded by the Federal Non Medical Use of Drugs Program, and conducted in conjunction with Operation Friendship, has confirmed this supposition. The methodology used in the study precludes generalization owing to the type of sample utilized. It found, however, that of seventeen elderly people (seven of whom indicated that they used alcohol), six were considered to be alcoholic. (Alcoholism was defined as "the chronic, usually daily, consumption of alcohol to the point of intoxication".)[8] There can be no doubt that a significant number of housebound elderly men and women in the inner city are suffering from the abuse of alcohol and drugs. No services exist to help them.

Physical Examination

Informants close to the skid row population have pointed to the lack of facilities for the health screening of these men and women. Even the Intoxication Recovery Centre and the Single Men's Hostel do not routinely do physical examinations, although they are in touch with large numbers of skid row men, and have nurses on their staff. (Of course, the Hostel rejects the men who are probably most in need of health screening, that is, the intoxicated men.) Little early identification and treatment of illness and injury is available for this group of inner city residents.

Home Health Aides

In the inner city is a great need for what might be called home health aides who could act as homemakers and provide such basic care as the bathing of bedridden patients. In discussions with the Edmonton Home Care Program it became obvious that the home care services are not really appropriate to inner city conditions. The Victorian Order of Nurses is willing to provide personal care to patients in the inner city, but a less trained worker who can supplement the professional work of the nurse, and so free the nurse to carry out more sophisticated procedures, is what is needed. Such a service is available in other large cities, but not yet in Edmonton. It could result in preventing or delaying hospitalization of patients and so be an economic saving as well as a social gain.

Long-Term Psychiatric Services

The need for long term follow-up and treatment of people with chronic psychiatric illnesses has already been mentioned. The Community Mental Health Nurses try to provide such a service but their heavy caseloads and limited psychiatric back-up militate against the effectiveness of their work.

Comprehensive Planning

There is a virtual absence of any persons or agencies willing to assume responsibility for comprehensive planning and supervision of services to patients. Many speak disparagingly of the inner city residents, criticizing them for following the welfare loops, going from agency to agency, and playing one agency off against another. Criticism should be directed, however, at the agencies themselves which allow and intentionally or unintentionally encourage this.

The social work profession seems to have gone far from its professed commitment to the enhancing of the total social functioning of the individual and the family unit, and has become increasingly trapped by specialization. Many of the inner city people are incapable of coping with the institutions of the broader society, and require the assistance of the helping professionals.

Gaps in inner city health services and the inadequacy of the existing agency programmes result in people not receiving the assistance they require.

FOOTNOTES

1. AID Service of Edmonton, 1976 Directory of Community Services for Edmonton and District.

2. Inner City Field Workers Group, "Health Service Delivery in McCauley, Boyle Street, and Riverdale Communities," p. 6.

3. Lu Ann Aday and Ronald Andersen, Development of Indices of Access to Medical Care.

4. This framework follows that used in David Mechanic, Medical Sociology, pp. 154-155.

5. Victor W. Sidel, "Can More Physicians be Attracted to Ghetto Practice," in John C. Norman (ed.), Medicine in the Ghetto, pp. 177.

6. Mechanic, Medical Sociology, p. 155.

7. I am grateful to Stanley Greenhill, M.D., for this information. See also Geoffrey E. Milligan, "Transient Men and Skid Row," p. 155.

8. Mary Lee Michael and Jim Reid, "Operation Friendship Service and Research Project on Elderly High Risk Group."

CHAPTER 8

THE ROLE OF COMMUNITY DEVELOPMENT IN IMPROVING HEALTH CARE

Introduction

The purpose of this chapter is to explore the role that community development could play in the inner city of Edmonton. It would be dangerous to assume without supporting evidence that community development, simply because of its professed goal of improving the quality of people's lives, is an appropriate vehicle for improving health. Community development is, after all, a specific approach to introducing change which is appropriate in some circumstances but inappropriate in others.

One of the crucial components of community development is the participation of the people it aims to help. This element is fundamental and appears in all approaches to community development including the conservative United Nations approach (a partnership between government and people) and the conflict strategies of Alinski (mass based people's organizations). There is a sense in which participation is itself a healthy, and health giving activity, as was discussed in Chapter 1. If health is seen as one's having a high degree of autonomy and control over one's lifestyle, then participation in activities which enhance this state is, by definition, health promoting.

In a more specific way, it can be argued that the activity of participation is itself intrinsically health giving. Warren sees it as a possible antidote to the modern affliction of alienation:

> Participation in the development of the community is an important preventive for the alienation of individuals in the mass society, over which they have no control and in which they feel no meaningful sense of participation.[1]

Furthermore, when we look at health in a more conventional, medically-oriented manner, we see an increasing need for participation.[2] Many of the most important causes of morbidity and mortality are not amenable to medical intervention. They are related to lifestyles. Motor vehicle accidents, suicides, cirrhosis of the liver -- these are among today's major health hazards and can only be prevented by change in lifestyles. What is required is participation: "participation in the sense of reaching out to take a hand in the determination of one's own fate and that of others."[3]

On the other hand, participation at a societal level is also required for the improving of levels of health. Inadequate sewerage, impure water supplies, overcrowding, poor food habits and poverty are all causally related to morbidity and mortality. They cannot be remedied by individual action. They are problems of public policy and require political action for their solution. Participation in the political processes which determine public policy and action in these health-related areas is one way to improve the quality of health in our society.

Popular participation in development, as both a goal of development and a means of development, is receiving considerable attention in international development circles. In United Nations agencies, community development is almost never mentioned; popular participation in development is now the favoured approach.[4] This is also apparent in the health field: the World Health Organization and UNICEF adopted similar policies in 1975. They observed that inadequate community involvement in health care is one of the main obstacles to improving health in the Third World, and further, that the poor countries which have shown the most dramatic improvements in the health of their people have all used major popular participation strategies.[5] This is particularly important at the crucial level of primary health care.[6]

Community development, however, is more than just popular participation or, as it is known in Canada, "citizen participation". Community development requires that people be organized in groups to get the kind of development they want. For community development to be effective, people have not only to organize, but through such organization, gain power. It is only by use of power that community development can help people to attain their development goals. Community development has been tried in the inner city of Edmonton, but it has not taken on the crucial task of transferring power.

Community Development -- The Local Experience

Community development, as a formal programme operating under that name, has had a chequered career in Alberta. It was introduced as a Government of Alberta programme in the Community Development Branch of the Department of Industry and Trade in 1964. It was transferred, with its personnel and programmes, to the Alberta Human Resources Development Authority in September 1968, and was phased out following the accession to power of the Progressive Conservative government in 1971.[7]

An Urban Community Development Officer position was created in Edmonton primarily to serve the native people. Mr. Joe Keeper, the incumbent, stated in 1966 that the thoughts behind the appointment of an Urban Community Development Officer for Edmonton were:

> (1) the orientation of city services for their clientele of Indian ancestry, [and]
> (2) the reaching of the people of Indian ancestry in order that they communicate in a meaningful way with the agencies concerned with Indian people.[8]

It is interesting that he made no mention of organizing the people, or helping them to organize themselves, which is, of course, the key role of a community development worker.

Mr. T. J. Garvin was the Urban Community Development Officer best known for his work in the inner city, designated during his time the "Urban Renewal Area". Garvin's perception of his role was closer to authentic community development than Keeper's. Garvin saw the community development task as being "to motivate and encourage people to take action towards their participation in the solution to the problems which confront them."[9] He did not hold with the development of a mass based community organization of the poor which was the community development strategy favoured at that time in many American inner city areas. His work was highly issue oriented:

> Some people, I am sure, felt that our aims [in community development] should be to develop brotherly love, fellowship, and community togetherness. There is no way in my opinion this would be possible in a community as heterogeneous as the Boyle Street Area of Edmonton. My approach has been to gather small groups of people around major issues . . .[10]

The groups he tried to organize included people with housing problems, widowed, separated and divorced women, drug users, female juvenile offenders and unwed mothers. It is interesting to note that one of the more successful agencies now operating in Boyle Street, Humans on Welfare, was formed with Garvin's assistance, but it must be concluded that the work of the Urban Community Development Officers in the inner city had little lasting effect.

During the years since the winding up of the Human Resources Development Authority, little community development work has been done in the inner city. Most agencies have carried on their traditional mission, social work or other service delivery activities, occasionally perhaps involving some local people in advisory capacities or as employees. (The Boyle Street Co-op, for example, has done this quite effectively.) "Development" has continued, "development" of the type that means demolishing people's homes and neighbourhoods and replacing them with such things as parking lots or commercial buildings.

In 1977, however, a number of happenings suggested that community development may again become important in Boyle Street and McCauley. In April, following pressure from a number of inner city agencies and elsewhere, city council allocated $100,000 to the city Planning Department to develop a community plan for the area.[11] The same month, the Edmonton based firm Co-West Associates completed a report on social needs in the inner city areas of Calgary and Edmonton. This study was commissioned by the Office of the Official Opposition, Legislative Assembly of Alberta, and it concluded that a community development process (not programme), should be applied in the areas to redirect resources in order to eliminate the many problems identified. Among these were the many health problems which have been discussed in earlier chapters.[12]

The Edmonton Social Planning Council has also been active. It prepared in September 1976 a proposal for a community development programme in Greater McCauley. This was not funded, so the proposal was rewritten in August 1977. It proposes a traditional community development programme of the type characterized by Rothman as the model A, locality development strategy.[13] The proposal is vaguely worded, but indicates that the major strategy will be to develop a "mass based democratic organization" and to utilize "a variety of tactics".[14]

The most recent and most important step has been the release, in September 1977, of the City of Edmonton Planning Department's proposal for the "Boyle Street/McCauley planning process", that is, the implementation of Council's April 1977 decision to fund the development of a community plan for the inner city.[15] The importance of the proposal is that the Planning Department intends to apply a "community development process" to the achieving of its aims. The Planning Department acknowledges both the Co-West Associates' report and the Social Planning Council's proposal as providing "a basis and framework for the formulation of the present proposal".[16]

Edmonton's development of a neighbourhood plan cum community development process in the inner city has obvious implications for health services. The proposal states that the three main areas for which planning is required are land use, housing, and "the delivery of social services in the planning area [which] will need to be planned, co-ordinated and evaluated in order to meet the needs of individuals and groups within the area".[17] It is not clear from the proposal that the city planners are aware what an immense task they have given themselves. Any activities aimed at improving health services in the inner city, particularly using a strategy of community involvement in the planning and delivery of these services, will have to be coordinated with the Planning Department's and Social Planning Council's community development activities.

Community Development in Health Care Delivery Systems

Community development has been effectively used in many countries as a way of improving the health of the people. Popular participation in development is now an internationally accepted strategy (albeit more often talked about than implemented), and in some countries people have applied this strategy in the form of specific community development programmes to improve health. A recent (1975) World Health Organization publication provides ten case studies from underdeveloped countries which document significant improvements in health care.[18] In every case, the forming, recognition or strengthening of local community organizations was crucial. In some countries this takes the form of nationally organized and coordinated mass based local development bodies, such as the Committees for the Defence of the Revolution in Cuba which have among their health tasks, the responsibility for ensuring that everybody receives polio immunizations.[19]

In other countries with more democratic political systems, traditional village level community development approaches are used. For example, in the Wenchi district of Ghana, a WHO sponsored pilot project on primary health care delivery systems is incorporating health projects in a local community development programme. Local committees use their own decision-making structures to determine priorities (health, education, agriculture, etc.), and experts are available to provide information, to suggest alternatives, and to advise what outside resources are available.[20] This was the type of community development advocated by the British Colonial Office thirty years ago.

In Papua New Guinea in recent years the writer has been involved in numerous village-level community development programmes in which the people identified improvements in health as high priority goals. Their projects included improving nutrition, sanitation, transport to aid posts and support of the work of village-level primary health care providers.

Finally, in this hemisphere, Dr. Héctor R. Acuña, Director of the Oficina Sanitaria Panamericana, the Regional Office of the World Health Organization, has recently spoken about the crucial role of community development in urban and rural health care in the Americas. He stresses the importance of communities organizing to meet their health objectives, and being educated so that they can effectively help themselves. He also refers to the importance of multisectoral approaches based on local conditions.[21] These are all traditional community development principles.

It is not only in the Third World that community development has been used to improve the health of the people. In North America, community development has often taken the form of small community organizations or neighbourhood associations which restrict themselves to particular narrow local objectives. The neighbourhood health centre movement is a good example of this.

The movement had its American origins in the social settlements started in the poorest areas of New York, Chicago and elsewhere in the 1890s. The provision of health care services was a very important part of their work. The neighbourhood health centre movement as such began around 1910 in response to the rapid growth of urban slums as a result of the massive immigration of people from south and east Europe. The health centre movement reached its peak during the 1930s, as the experience of World War One taught the importance of coordination of services and of primary health care.

In 1930, a study identified 1,511 health centres in the United States, of which 80 per cent had been established since 1910. The movement declined in the late 1930s as it became superceded by newer forms of health and social service delivery systems, but reappeared thirty years later as part of the U.S. Federal government's programmes in the war on poverty.[22]

Neighbourhood health centres are also found in Canada, and a number are in the West, for example, the Mount Carmel Clinic in Winnipeg, the Inglewood Centre in Calgary, and the Downtown Community Health Society in Vancouver. These three centres are located in the inner core areas of their respective cities and serve the local people, including those from skid row. Their Boards of Directors and staff include local people, their services and methods of operation are designed to meet specific local needs, and they offer a variety of services using a coordinated, total care approach. In each case they are funded by provincial health departments but operate autonomously.

Vancouver's Downtown Community Health Society is a good example of this approach to community development in health care. The centre is located in and mainly serves the "skid road" community of Vancouver. Its goal is "to provide and promote services for Health and well-being of the local community in ways that are acceptable to the community". Its stated philosophy is that "local people should act as a bridge between the professional and the lifestyles of the local community and receive training to enable them to deliver health care to their peers". Their mode of operation, based on community development principles, is that "the community, acting collectively determine their Health Care and other needs, aided and assisted by professional health workers and persons outside the community who have special skills to offer". The Society's services include a medical clinic, an information and referral service, a dental clinic, welfare services and a home care programme. Forty-eight per cent of the staff are drawn from the skid row area which the centre serves. The members (the local community) annually elect the sixteen-person Board of Directors, of whom only six are staff of the Society.[23] Health facilities such as this can be extremely effective in overcoming the inadequacies of inner city health care delivery systems that were discussed in previous chapters.

Neighbourhood health centres (NHCs) are also important in the inner areas, slums and ghettos of the cities of the United States. The modern moves towards this form of health care delivery came with the U.S. war on poverty which commenced in 1964. NHCs were widely established through the programmes of the Office of Economic Opportunity (OEO) and later the Model Cities programmes. The phasing out of these programmes began in the early 1970s and since then local sponsorship and federal Department of Health, Education, and Welfare funds have been utilized. By 1972 there were about 100 OEO funded and 29 Health, Education, and Welfare funded NHCs in the United States, serving over 5 million people.[24]

The American neighbourhood health centres experience is of particular relevance to our topic because of the "maximum feasible participation" requirement of the OEO and early Model Cities programmes. Here we have what amounted to a national community development programme, American style, which started with high hopes of eliminating poverty and distress in our lifetime, and withered away some ten years later.

There was never enough money. The Viet Nam war drained off financial resources. The Model Cities funds were spread too thinly: the original plan was to develop six or eight Model Cities programmes to get maximum benefit from the available funds, but for political reasons the programme was expanded to some 147 cities.[25] Many consider that the programmes failed because too much emphasis was placed on the advice of unskilled social scientists regarding the importance of the active participation of the poor.[26]

NHCs were usually established in slum and ghetto areas. They were designed to provide health services to those who had not been covered by the existing health services. Some of the most important "new" concepts involved were maximum feasible participation, contracting with unorthodox agencies for health care, and using the health care system to solve the poor's social problems, e.g. unemployment, lack of educational opportunities, or poor nutrition. The projects were based on the premise that medical care is a basic right, and that federal funds should be used to guarantee this right.[27]

Numerous evaluative studies were undertaken. Generally they were favourable. One evaluation of 33 OEO funded NHCs, published in 1971, concluded that, at that time, the programme was successful. Most NHCs were providing good quality medical care (22 of the 33 were better than the average hospital outpatient department), comprehensive services, continuity of care, and local community manpower training and utilization. The costs of clinical services were comparable to those of private providers.[28] Some authors are not so convinced of the value of NHCs, particularly since the centres were largely evaluated against government criteria and were usually not compared with other health delivery systems.[29]

The NHC projects are of special interest to community development because of two key issues: (1) the ways the centres were established, and (2) community control. Of course, these matters are interrelated. The methods of establishing NHCs varied considerably, but all had to fall within broad OEO and later Model Cities guidelines. It was essentially a political process, involving complex power relationships between the funding source (OEO), the sponsoring agencies (usually medicine-dominated), and the clientele. Some were established with "top-down" sponsorship, that is, outsiders, often professionals, established the centres according to their ideas of what was most appropriate. Others were established with "bottom-up" sponsorship, that is, based on local organizations of local people. The usual experience was that with "top-down" sponsorship, the centre had a fast start but soon ran into conflicts over control. Where "bottom-up" sponsorship was used, the centres developed slowly but were more stable because control remained in the community from the start.[30]

Community control almost always became an issue. At the early stage of the war on poverty, "maximum feasible participation" was the policy, but this was watered down under Model Cities to "democratically selected" community involvement. Typically, NHCs went through four phases of development:

1. token involvement of the people,
2. confrontation between the community advisory board and the sponsors when the clientele realized that the centre was not meeting their needs,

3. complete disequilibrium, followed by negotiation which resulted in cooperation, and (hopefully)
4. success: "compassionate, comprehensive, family-centred care".

Tension was almost inevitable because of the different methods of influence used by the groups involved; in particular, the sponsors, usually medical professionals, used rational persuasion and influence; the clientele -- the community -- used coercion.[31]

Community control of health facilities in the United States was as much a matter of ideology as of methodology. The literature of the 1960s and early 1970s abounds with such statements as:

> From the standpoint of planning, design and operation of health services for the poor it is an absolute necessity that the poor themselves say what it is they want and how they will accept what is designed.[32]

No evidence for this "absolute necessity" is given by the author, and it was programmes based on these flimsy foundations that resulted in what Daniel Moynihan called "maximum feasible misunderstanding". None the less, a degree of local control was usual in the NHCs, and along with this approach came the danger of compromising the quality of professional services. Always present was the problem of community leaders gaining so much control that their activities became dysfunctional. Talking about health care in the slums in 1969, Norman says:

> Woefully, however, citizen participation [in NHCs] today has fallen prey too often to the self-serving ambition of would-be leaders on one side, or the undoing indulgence of unseasoned or inept medical practitioners on the other. The result is that the patient group, for whom the advisory council and/or community medical centre allegedly was formed, becomes a pawn lost in the contest for control.[33]

The patients inevitably received second-class care when the administration and professionals were affected by community control in such a way that the quality of their professional work was reduced. This can easily result in what is in effect a dual system of health care organization: "a system good enough for the poor and a system demanded by the rich".[34]

It must be stated, however, that many of these issues were time and place specific. Community control was related to the increasing acceptance of contest strategies of social change in the United States in the late 1960s. We have now gone beyond this because such strategies have been shown to be relatively ineffective. American NHCs were essentially part of a larger programme of local neighbourhood improvement, and were usually established in slums, ghettos and other poor areas where the people were already relatively organized.

These conditions are quite different from the situation in Edmonton today, and so great caution must be used in drawing conclusions from the American experience and in applying them locally. The American experience is valuable, though, in sensitizing us to some of the key issues in applying community development principles to health care systems in the inner city.

The feasibility of community development in the Boyle Street/ McCauley area will now be considered. Community development has worked well in many American slum and ghetto neighbourhoods, but they are, in many ways, different from the corresponding neighbourhoods in Edmonton. It is the nature of community in an inner city, and the psychological and social characteristics of the people which determine aspects of their organization and integration.

Sociologists express conflicting views about the degree to which social integration, or a sense of community, exists in the inner city. Roland Warren's approach to community is useful in this context.

He considers community to be "the combination of social units and systems which perform the major social functions having local relevance", and these functions are

1. production -- distribution -- consumption
2. socialization
3. social control
4. social participation, and
5. mutual support.[35]

To what degree do inner city areas fulfill these functions?

First, as mentioned in Chapter 4, the people with lower socio-economic status have a low rate of affiliation with formal associations (churches, clubs, societies, etc.). It is through such organizations that many of the functions of a community take place.

Secondly, the neighbourhoods Gans calls "ethnic villages" tend to show a high level of social integration. They are real communities and fulfill well the functions listed above. Suttles' study of the Near West Side of Chicago, a depressed slum area, revealed a complex network of social relationships, real communities based on race, ethnicity, and similarity of interests. The Italian, Mexican, Puerto Rican and Negro groups exhibited clear differences in social organization and were territorially differentiated, but each group provided its members with security and a sense of belonging.[36] Similar findings have been reported from Boston's West End among the slum-dwelling communities of people with Italian, Polish and Jewish backgrounds.[37] In these kinds of communities, the informal organization of the people satisfies many of the functions of community, in the same way that formal organizations do in more affluent neighbourhoods.

Thirdly, confusion appears in the literature when authors generalize about inner city areas and fail to differentiate between low income/low rent areas and skid row. Many studies, such as those just mentioned, show the network of social relationships that exist in poor areas of the "urban village" type. Studies of skid row and rooming-house areas, on the other hand, often reveal high levels of personal isolation, alienation and social disintegration.[38] In Chapter 4 reference was made to studies which have shown that most of the men in skid row are not degenerate drifters nor alcoholics. They tend to be low income unskilled workers relatively disaffiliated from the social organization of the broader society. They have their own codes of behaviour and their own sense of community.

Bogue's Chicago skid row study revealed that only 22 per cent of the men in his sample were "assimilated", that is, well integrated, and felt they "belonged". Fifty per cent were "aloof" or "withdrawn". The heavy drinkers tended to be better integrated than the not so heavy drinkers. He concluded that the skid row men "have so little 'we-feeling' that it seems almost a contradiction in terms to speak of a 'Skid Row society'".[39] He uses the concept of undersocialization to describe these dynamics.

Other researchers have come to quite different conclusions. Wisemen found a high degree of conviviality and activity among skid row alcoholics. Wallace considers Bogue's conclusion to be the result of faulty research methodology, as Wallace's Minneapolis research revealed a real skid row way of life that met people's needs.

> [The skid rower] has managed to evolve on his own behalf a community of sorts, a community which shelters, clothes, and feeds him, and even keeps him supplied with drink. He asks for nothing more.[40]

A variety of views has also been expressed regarding Edmonton's inner city. One informant described Boyle Street as being closer to a real community than any other neighbourhood in the whole of Edmonton. The native people in Boyle Street and McCauley certainly have a sense of community and a social structure which meets adequately Warren's concept of community. Persistent drinking and alienation from non-native society are central components of their lifestyle, but these provide social cohesion and identity for the people involved.[41] The Chinese, Italian and other ethnic groups, while very different, are also real communities in Warren's terms.

The non-native men of Edmonton's skid row do not compose a community. Admittedly they do have a complex mutual support system, but in no manner does it satisfy the criteria for community.

Garvin and Milligan each tried to organize the skid row men in Edmonton by applying the community development process, but neither was successful. Milligan tried to develop two local leaders in 1969, but they rapidly adopted elitist roles and were ineffective. Milligan blamed lack of time and skill on his part for the failure.[42] Garvin believed that community development was possible in Boyle Street, but his attempts in this direction in 1968 failed. Again, shortage of time was said to be at least part of the reason for his lack of success.[43] The feasibility of organizing Edmonton's skid row men for self-help, or for involvement in the operation of social agencies remains doubtful. Community development is possible in McCauley and among the ethnic groups but much less so among the members of Edmonton's skid row.

A Community Health Facility in Edmonton's Inner City

In the previous chapter some of the serious inadequacies and gaps in Edmonton's inner city health services were described. It is obvious the health and health care services in the inner city are inadequate. A new kind of health programme is required, one appropriate to the inner city. The discussion in this and previous chapters has led to the conclusion that a comprehensive community health facility is needed in the inner city, and that a community development process would be an effective way of establishing it. Community development has not been tried in the inner city (except briefly on skid row). The remainder of this chapter will outline one possible way that community development could be used to establish a community health facility in the inner city.

Experiences elsewhere and community development theory strongly suggest that this process is well suited to establishing community health facilities in deprived areas. Involving the people in the planning, operation and evaluation of programmes designed for their own benefit is highly desirable. It is more effective in this kind of area than programmes imposed by outside professionals who have only limited knowledge and understanding of the people's needs and potentialities.

The community development process should be based on the consensus model. Any interested person or agency should feel free to become involved in the process. It should aim to serve all the people of the locality. The more informed people in the area, including the staff and local volunteers of the social agencies, are both interested and motivated to act to establish a health facility. The wide publicity given the report on Community Health Resources for the Inner City of Edmonton has helped facilitate the process. The community development process could be implemented as follows:

1. Initiation of the Project. A project director and a number of community development field workers would be appointed. The project director would be an individual experienced in the health care and community organization fields. He should not be a physician, and should not expect to be appointed director of the facility when established. The community development field workers should work with trained local people.

2. Study and Motivation Phase. The community development staff would visit the agencies and meet the local people in their homes and other gathering places for informal discussions. They would learn about people's attitudes to sickness and health, their felt needs, their ideas about solutions to their problems, and their willingness to become involved in a community organization. The inner city report could provide a basis for many of these discussions.

Through these techniques, the field workers could seek to identify local leaders. They would explain the alternatives open and the value of the community development strategy. This would sensitize the people and encourage them to act on their own behalf.

Particularly at this stage, the inner city staff must coordinate their efforts with those of the staff of the city Planning Department, if Edmonton's proposed community development project has begun.

3. Ad Hoc Committee. Following the study and motivation phase, an ad hoc committee could be formed. Membership would be open to all interested persons, but care must be taken by the project staff to ensure that the committee is not dominated by agency personnel or other outside professionals. The committee could be — and probably should be — large, possibly 30 or 40. This would enable the representation

of a wide variety of people, including existing and potential indigenous leaders.

4. Publicity and Facility Design. The committee, operating through sub-committees, would commence working with the project staff to continue the information dissemination process. They would continue to talk actively to the large numbers of people with whom they would be in contact about the range of alternatives available -- the possible types of health facilities and the processes of establishing one in the inner city. Video-tape and other communication technology would be utilized.

In conjunction with the project staff and outside expert advisors, the ad hoc committee would commence to design the health facility. Decisions would be made on physical aspects, such as location and floor plan, and on such policy matters as the programmes and services to be provided by the facility, staffing, funding, training of indigenous staff and outside professionals, etc. Of particular importance would be decisions about the control of the facility, especially the powers and responsibilities of the hired professional staff on the one hand and community representatives on the other. The facility director would need to be hired at this time.

5. Establishment of the Facility. From this stage on, the process would be dependent upon the decisions made by the ad hoc committee and the facility staff. The original project director's role would start to come to an end as the committee and facility staff take over full responsibility. Community development staff, however, would still need to be involved in the on-going process.

In similar facilities elsewhere, the process often continues with the registration of members (the potential users of the facility), the hiring of staff, the establishment of the physical facilities and the development of programmes and service arrangements. An opening ceremony could be held, as it would have a valuable community-building function.

6. Permanent Control Arrangements. Once the facility were established and had commenced operation, the role of the ad hoc committee would be over and it would be necessary to develop permanent control arrangements. The committee may decide to hold elections for directors. Decisions would have to be made about the ratio of board members who live in the community (i.e. facility users) to facility staff, and perhaps social agency representatives. The responsibilities of the staff and board of directors respectively would have to be carefully negotiated and defined.

7. On-going Arrangements. The specialist community development input would need to be on-going, after the establishment of the facility, to assist the directors, the staff, and the authorities to evolve appropriate operating arrangements.

In addition, an evaluation component would have to be built into the community development process from the very beginning, to ensure that decisions were made on the basis of full and accurate information.

A community development project along these lines could readily be employed in Edmonton's inner city. A careful blend of professional and local input, and a high degree of local control, could be effective in improving the health of the inner city people. This process would ensure that the facility was congruent with the unique social characteristics of the people of the area, and would be instrumental in helping them to meet their unique needs.

Summary

Community development can be very effective in improving the health of the people. Many programmes operate in the Third World in which local communities are responsible for primary health care. In the United States and Canada community controlled neighbourhood health centres are also very effective, especially in depressed inner city areas. In these cases, however, there is an ever present problem of balancing community control and a high level of health care: an excess of radical local control or of professional (medical) dominance can result in a less than optimal level of service.

Community development was briefly, and unsuccessfully, attempted in Edmonton's skid row area some ten years ago, but has not been attempted among the majority of the inner city people. Sufficient sense of community and potential for organization exists in the inner city for community development to be quite feasible there. In fact, both the Edmonton Social Planning Council and the City of Edmonton Planning Department are currently (1978) proposing comprehensive community development programmes for that area.

Health in Edmonton's inner city would be significantly improved if an appropriate facility were established there: a community health centre under local control, responsive to the unique needs of the inner city people. A community development project which could achieve this objective has been outlined.

FOOTNOTES

1. Roland L. Warren, Truth, Love and Social Change, p. 87.

2. This and the next paragraph follow Laurence C. Howard, "Decentralization and Citizen Participation in Health Services", Public Administration Review 32 (special issue October 1972): 702-707.

3. Ibid., p. 707.

4. United Nations, Department of Economic and Social Affairs, Popular Participation in Decision Making for Development; and Popular Participation in Development: Emerging Trends in Community Development.

5. World Health Organization, Alternative Approaches to Meeting Basic Health Needs in Developing Countries, pp. 16-17, 98-99.

6. I. Adeniyi-Jones, "Community Involvement: New Approaches", WHO Chronicle 30 (1976): 8-10.

7. Isaac N. Glick, "An Analysis of the Human Resources Development Authority in Alberta", pp. 1-48.

8. Keeper to J. R. Whitford, Provincial Co-ordinator of Community Development, Alberta, 12 December 1966, reprinted in George Kupfer, Edmonton Study, pp. 301-302.

9. Terry J. Garvin, interview, in Geoffrey E. Milligan, "Transient Men and Skid Row", p. 123.

10. Terry J. Garvin, "Urban Renewal Area. Annual Report, June 16, 1969", p. 2.

11. Edmonton Journal, 21 April 1977.

12. Co-West Associates, "Identification of Social Needs in the Inner City -- Edmonton and Calgary."

13. Jack Rothman, "Three Models of Community Organization Practice" Social Work Practice.

14. Edmonton Social Planning Council, "A Proposal for a Three Year Community Development Project in the Greater McCauley District of Edmonton, Alberta", p. 3.

15. Edmonton, Planning Department, Area Planning and Special Projects, Boyle Street/McCauley Planning Process.

16. Ibid., title page.

17. Ibid., p. 2.

18. World Health Organization, Health By the People.

19. Adolfo Valdivia Dominguez, "Stimulating Community Involvement through Mass Organizations in Cuba: The Women's Role", International Journal of Health Education 20, no. 1 (1977): 57.

20. Jerome Stromberg, "Community Involvement in Solving Local Health Problems in Ghana", Inquiry 10, no. 2, (Supplement, June 1975).

21. Héctor R. Acuña, "Community Participation in the Development of Primary Health Services", Bulletin of the Pan American Health Organization 11, no. 2 (1977): 98.

22. A history of the first U.S. neighbourhood health centre movement, from which this summary is taken, can be found in George Rosen, From Medical Police to Social Medicine, pp. 304-324.

23. This description is taken from the Society's brochure, "Downtown Community Health Society". (undated). Their address is 373 East Cordova St., Vancouver, B.C., V6A 1L4.

24. M. Aloise Ann Zasowska, "The Philosophical Index of Health Care Delivery in Our Culture", in Health Care Issues, ed. Madeleine Leininger and Gary Buck, p. 11.

25. George J. Washnis, Community Development Strategies, p. 5.

26. See especially Daniel P. Moynihan, Maximum Feasible Misunderstanding.

27. John C. Norman, Medicine in the Ghetto, p. 35.

28. Gerald Sparer and J. Johnson, "Evaluation of OEO Neighbourhood Health Centers", American Journal of Public Health 61 (1971): 931-942.

29. Patricia L. Kendall and George G. Reader, "Contribution of Sociology to Medicine", in Handbook of Medical Sociology, ed. Howard E. Freeman, Sol Levine and Leo G. Reeder, p. 24.

30. Howard, "Decentralization and Citizen Participation in Health Services", pp. 707-708.

31. This is based on Jeoffry B. Gordon, "The Politics of Community Medicine Projects: A Conflict Analysis", Medical Care 7, no.6 (1969): 419-428.

32. George A. Silver, "What Has Been Learned About the Delivery of Health Care Services to the Ghetto?", in Medicine in the Ghetto, ed. Norman, pp. 69-70.

33. Norman, Medicine in the Ghetto, p. 281.

34. Leonard W. Cronkhite, "What are the Conflicts Involved in Community Control?", in Medicine in the Ghetto, ed. Norman, p. 284.

35. Roland L. Warren, The Community In America, pp. 9-10.

36. Gerald D. Suttles, The Social Order of the Slum.

37. Marc Fried and Peggy Gleicher, "Some Sources of Residential Satisfaction in an Urban Slum", in The Sociology of the City, ed. Sandor Halebsky, p. 413.

38. Noel P. Gist and Sylvia Fleis Fava, Urban Sociology, p. 369.

39. Donald J. Bogue, Skid Row in American Cities, pp. 152-153.

40. Jacqueline P. Wiseman, Stations of the Lost, pp. 38, 41-43; Samuel E. Wallace, Skid Row as a Way of Life, pp. 25, 156-160.

41. Hugh Brody, Indians on Skid Row.

42. Milligan, "Transient Men and Skid Row", pp. 126-133.

43. Ibid., p. 123.

CHAPTER 9

SUMMARY AND RECOMMENDATIONS

Summary

Health and development are very closely related concepts. This relationship becomes particularly apparent when we look at underdeveloped communities, both here and abroad. Health is more than the absence of disease, and health care is more than treatment of illnesses. People are healthy when they are able to function in ways that enable them to achieve their potential as individuals. Development is the process whereby people move towards the satisfaction of their basic needs, and gain an increasing degree of control over the forces that determine the way they live. Community development is a process, expressed in action programmes, whereby people, working together in groups and using their own resources and those of the broader society, attain a higher level of development.

The inner city of Edmonton, specifically Boyle Street and McCauley, is an "underdeveloped area". It contains some 15,000 people. The population is heterogeneous but the stereotype that the area is inhabited largely by drunks and "ne'er-do-wells" is false. The majority of the people are stable, well established citizens. It is a minority that constitutes the transient and "skid row" population.

The morbidity patterns of the inner city of Edmonton are similar to those found in the corresponding regions of other North American cities. Demographic factors and the lifestyles of the inhabitants of the area largely determine the extent and type of illnesses found. The geriatric problems of the elderly are intensified by their isolation from family and society. In children, the main causes of ill health are related to poor nutritional status and inadequate home care. The small skid row population has a morbidity pattern related to poor nutrition, violence, drinking, exposure to the elements and poor housing. The incidence of some illnesses e.g. malnutrition, pneumonia, and tuberculosis, is higher in the inner city than in more affluent neighbourhoods. The severity of some illnesses e.g. alcohol abuse and injuries, makes them more apparent to the casual observer.

The City of Edmonton is well supplied with health personnel and has a wide range of health and health related services. In the inner core of the city, medical care is perceived to be either unavailable or inaccessible. The doctor/population ratio is lower than for the city at large, and the cultural, ethnic and demographic characteristics of those living in the inner city result in low utilization of the available medical resources.

Communication between health professionals and those living in the inner city is less effective than might be expected. This can probably be explained on the basis of differences in background and attitudes. The health care resources of Edmonton may well suit the majority of Edmontonians but are less satisfactory for the inner city people. The result is that existing services and facilities are either not used or used in ways considered inappropriate by health professionals. Many of those living in the inner city either perceive sickness in different terms from the majority of citizens, or place different values on the significance of signs and symptoms.

Large numbers of the inner city people fail to make appropriate use of existing city health and medical care resources. However, in their own district few such resources exist. Social, cultural, and economic determinants tend to prevent the inner city people from seeking medical and health care in districts other than their own.

Only one private physician practises in the inner city. It is considered unlikely that other doctors will set up practice in the area despite the observed need. The area is not regarded as an attractive milieu for entrepreneur medical practices.

Community development is one way of helping people to improve their health status. The neighbourhood health centre approach has been tried in many North American cities with varying degrees of success. One of the key elements, and the one of most interest to community development workers, is the degree and type of local community control of the health centres. Community control should result in services appropriate to the needs of the people, but community control increases the risk of a lower standard of professional care. Organized community involvement in inner city health facilities will depend to a large degree on the feasibility of organizing the people. The City of Edmonton Planning Department and others are currently attempting to do this, but doubts arise as to the likelihood of success among the skid row and other alienated minority groups. Among the majority of the inner city residents, however, a community development programme is quite feasible. Activities aimed at improving health in the inner city must be coordinated with community development activities in other fields. Health cannot be divorced from other components of development.

Recommendations

The following recommendations are based on the findings of this study.

1. That a serious attempt be made to rationalize the existing health and related services now provided by a variety of voluntary and statutory agencies in the inner city. Rationalization of existing and proposed services would reduce overlap, alleviate confusion and enable services and programmes to meet more effectively the needs of the inner city people.

2. That the unique demographic, cultural and socio-economic characteristics of those living in the area warrant the establishment of a new and appropriate medical and health care facility.

3. That such a facility provide a variety of services aiming at comprehensive primary health care, including medical, dental, nursing, social work, domicilary, outreach and other services. These should be coordinated to reduce the need for visits to a variety of offices, and the repeating of documentation.

4. That the location and staffing of such a facility also be carefully considered to ensure optimal utilization. The facility should be physically accessible to the potential clientele. The team of health personnel must be appropriate to the needs of the clientele. The University of Alberta and other tertiary institutions could consider the use of the proposed facility as a site for approved field work. Senior students from medicine, nursing, dentistry, social work and community development, for example, could there obtain valuable learning and service experiences.

5. That the physical facility have the capability of handling acute short term conditions -- intoxications, detoxification, overnight observation, etc. -- so avoiding unnecessary use of hospital emergency departments and/or expensive acute hospital beds. An outreach programme should complement the short term inpatient care services.

6. That the facility, by its location and physical characteristics, be suited to the peculiar needs of the inner city people -- not too modern to intimidate potential users, nor so nondescript as to preclude its being viable as a health and medical care centre.

7. That the community development process be used in the establishment of such a facility. This would involve educating the inner city people regarding the possibilities for improved health care, organizing them into a policy-making and executive body, and helping them negotiate with the authorities to establish an appropriate health facility under the community's control.

An effective community health facility for the people of Edmonton's inner city could become a reality in a very short time if the Government of the Province of Alberta accepts its responsibility for the well-being of the people of this neighbourhood. The people of Edmonton's inner city are the casualities of the rapid changes now taking place in our society. It is surely the responsibility of both levels of government -- municipal and provincial -- to see that these inequalities are eradicated. It is incongruous that such "under-development" exists in the midst of so much apparent wealth.

BIBLIOGRAPHY

ACUÑA, Héctor R. "Community Participation in the Development of Primary Health Services." Editorial. *Bulletin of the Pan American Health Organization* II, no.2(1977): 95-99.

ADAY, Lu Ann, and ANDERSEN, Ronald. *Development of Indices of Access To Medical Care*. Ann Arbor, Michigan: Health Administration Press, University of Michigan, 1975.

ADENIYI-JONES, I. "Community Involvement: New Approaches." *WHO Chronicle* 30 (1976): 8-10.

AID SERVICE OF EDMONTON. *1976 Directory of Community Services for Edmonton and District*. Edmonton: Aid Service of Edmonton, 1976.

ALBERTA, Department of Social Services and Community Health. *Report of the Task Force to Study the Problems of Venereal Disease in the Province of Alberta to the Minister of Social Services and Community Health*. [Edmonton:] Dept. of Social Services and Community Health, 1976.

ALBERTA, Task Force on Suicides. *Report of the Task Force on Suicides to the Minister of Social Services and Community Health*. Menno Boldt, Chairman. [Edmonton: The Task Force,] 1976.

ALINSKI, Saul D. *Reveille For Radicals*. New York: Vintage Books Edition, Random House, 1969.

________. "What is the Role of Community Organization in Bargaining with the Establishment for Health Care Services?" In *Medicine in the Ghetto*, pp. 291-299. Edited by John C. Norman. New York: Appleton-Century-Crofts, 1969.

ALLSOP, Kenneth. *Hard Travellin': The Hobo and his History*. New York: New American Library, 1967.

ANDERSON, Nels. *The Urban Community: A World Perspective*. New York: Holt, Rinehart & Winston, 1959.

________. *The Hobo: The Sociology of the Homeless Man*. Chicago: University of Chicago Press. Phoenix Books, 1961 (c 1923).

ARMITAGE, Andrew. *Social Welfare in Canada: Ideals and Realities*. Toronto: McClelland & Stewart, 1975.

ARNSTEIN, Sherry R. "A Ladder of Citizen Participation." *American Institute of Planners Journal* 35, no. 4 (1969): 216-224.

BELL, Wendell, and FORCE, Maryanne T. "Urban Neighbourhood Types and Participation in Formal Associations." In The Sociology of the City, pp. 364-379. Edited by Sandor Halebsky. New York: Charles Scribner's Sons, 1973.

BERNARD, André; LÉVEILLÉ, Jacques; and LORD, Guy. Profile Edmonton: The Political and Administrative Structure of the Metropolitan Region of Edmonton. Ministry of State for Urban Affairs. Ottawa: Information Canada, 1974.

BIDDLE, William W., and BIDDLE, Loureide J. The Community Development Process: The Rediscovery of Local Initiative. New York: Holt, Rinehart & Winston, 1965.

BLISHEN, Bernard R. Doctors and Doctrines: The Ideology of Medical Care in Canada. [Toronto]: University of Toronto Press, 1969.

BOGUE, Donald J. Skid Row in American Cities. Chicago: University of Chicago, Community and Family Study Center, 1963.

BRODY, Hugh. Indians on Skid Row: The Role of Alcohol and Community in the Adaptive Process of Indian Urban Migrants. Ottawa: Information Canada, 1971.

BROOKS, Wendy G. "Health Care and Poor People." In Citizen Participation: Effecting Community Change, pp. 110-128. Edited by Edgar S. Cahn and Barry A. Passett. New York: Praeger, 1971.

BROWN, Richard H. "Community Development and Public Health." Kurukshetra 14, no. 6 (1966): 11.

BULLOUGH, Bonnie, and BULLOUGH, Vern L. Poverty, Ethnic Identity, and Health Care. New York: Appleton-Century-Crofts, 1972.

BURGESS, Ernest W. "The Growth of the City: An Introduction to a Research Project." In The City, pp. 47-62. By Robert E. Park, Ernest W. Burgess and Roderick D. McKenzie, with an introduction by Morris Janowitz. Chicago: University of Chicago Press, 1967.

CAMPBELL, J. D. The Municipality and Comprehensive Health Care Services in Province of Alberta. mimeo. n.p. n.d.

________. Report to the Public Affairs Committee of the Council of the City of Edmonton re: Municipal-Provincial Relationships under Comprehensive Health Care as applicable to the City of Edmonton. May 1972.

CANADA, Department of Finance. Economic Review, May 1977. Ottawa: Queen's Printer, 1977.

CANADA, Department of National Health and Welfare, Long Range Health Planning Branch. Health Field Indicators - Canada and Provinces. By John R. McWhinnie, Barbara L. Ouellet, and Jean-Marie Lance. Ottawa: Health and Welfare Canada, December 1976.

COE, Rodney M. *Sociology of Medicine*. New York: McGraw-Hill, 1970.

COLE, Stephen. *The Sociological Method*. 2nd ed. Chicago: Rand McNally, 1976.

COLEMAN, Richard P., and NEUGARTEN, Bernice L. *Social Status in the City*. San Francisco: Jossey-Bass, 1971.

CO-WEST ASSOCIATES. "Identification of Social Needs in the Inner City - Edmonton and Calgary." Edmonton: Co-West Associates, April 1977. Mimeographed.

CRAIG, J. David. "Report to the Board of the Alberta Human Rights and Civil Liberties Association on the Current Handling of Intoxicated Persons in Edmonton's Inner City." March 1976. Mimeographed.

CRONKHITE, Leonard W. "What are the Conflicts Involved in Community Control?" In *Medicine in the Ghetto*, pp. 283-289. Edited by John C. Norman. New York: Appleton-Century-Crofts, 1969.

D'AMORE, L. J., and Associates. *Social Impact Study of the Stadium for the Commonwealth Games*. n.p., March 1975.

DOSMAN, Edgar J. *Indians*: *The Urban Dilemma*. Toronto: McClelland and Stewart, 1972.

DOUGLASS, Chester W. "Consumer Influence in Health Planning in The Urban Ghetto." *Inquiry* 12, no. 2 (1975): 157-163.

EDMONTON, Edmonton Parks and Recreation. *Edmonton Parks and Recreation Master Plan 1970-1980*. Edmonton: 1972.

EDMONTON, Edmonton Social Services, Social Planning Section, and the Society for the Retired and Semi-Retired. *Edmonton Services to the Elderly*: *1974*. Edmonton, 1974.

EDMONTON, Edmonton Social Services, Social Planning Unit, and the Native Secretariat. *The Native in Edmonton*: *A Report on Some of the Problems Experienced by Natives in the City*. Edmonton: 1976.

EDMONTON, Planning Department, Urban Renewal Division. *Urban Renewal Concept Report*. March 1967.

________. *Urban Renewal Report*. 1967.

EDMONTON, Planning Department, Rehabilitation and Redevelopment Branch. *The Boyle Street Study*. April 1971.

EDMONTON, Planning Department. *Neighbourhood Improvement*: *A Planning Approach to the Inner City Neighbourhood*. August 1974.

________. *Older Neighbourhoods in Edmonton*: *A Planning Perspective*. n.d. [July 1975]. (formerly Neighbourhood Improvement Study, August 1974).

EDMONTON, Planning Department. *Housing in Edmonton*: *Directions for the Future*. Research Report Number 13. February 1976.

EDMONTON, Planning Department, Community Planning. *Riverdale Community Plan*. August 1977.

EDMONTON, Planning Department, Area Planning and Special Projects. *Boyle Street/McCauley Planning Process*. *Proposal Outline*. Working Paper No. 1. September 1977.

EDMONTON HOME CARE PROGRAM. *Report of the Edmonton Home Care Program. January 1, 1975 - December 31, 1975*.

EDMONTON INTER-FAITH SOCIETY. *McCauley Boyle Street Study*. n.p. n.d. [Edmonton: 1975].

EDMONTON LOCAL BOARD OF HEALTH. *Report of the Local Board of Health*. (annually).

EDMONTON SOCIAL PLANNING COUNCIL. "A Proposal for a Three Year Community Development Project in the Greater McCauley District of Edmonton, Alberta." (typescript) August 1977.

EDMONTON WOMEN'S SHELTER LTD. *A Study of the Developmental Program of the Women's Overnight Shelter, Edmonton*. *January 23, 1970 - May 23, 1973*. Edmonton, 1973.

FILSTEAD, William J. (ed.). *Qualitative Methodology*: *Firsthand Involvement with the Social World*. Chicago: Markham, 1970.

FOREMAN, Paul B. "The Theory of Case Studies." In *Research Methods*: *Issues and Insights*, pp. 187-205. Edited by Billy J. Franklin and Harold W. Osborne. Belmont, California: Wadsworth, 1971.

FREEMAN, Howard E.; LEVINE, Sol; and REEDER, Leo G. (eds.). *Handbook of Medical Sociology*. 2nd Ed. Englewood Cliffs, N.J.: Prentice-Hall, 1972.

FREIRE, Paulo. *Pedagogy of the Oppressed*. Trans. by Myra Bergman Ramos, 1968. New York: Seabury Press (A Continuum Book), n.d. [1970].

FRIED, Marc, and GLEICHER, Peggy. "Some Sources of Residential Satisfaction in an Urban Slum." In *The Sociology of the City*, pp. 395-414. Edited by Sandor Halebsky. New York: Charles Scribner's Sons, 1973.

GANS, Herbert J. *The Urban Villagers*: *Group and Class in the Life of Italian-Americans*. New York: Free Press of Glencoe, 1962.

________. *People and Plans*: *Essays on Urban Problems and Solutions*. New York: Basic Books, 1968.

GARVIN, Terry J. "Urban Community Development. Annual Report, July 1968." [Edmonton: Human Resources Development Authority] Mimeographed.

GARVIN, Terry J. "Urban Renewal Area. Annual Report, June 16, 1969." [Edmonton: Human Resources Development Authority] Mimeographed.

GILL, Richard T. Economic Development: Past and Present. Englewood-cliffs, N.J.: Prentice-Hall, 1963.

GIST, Noel P., and FAVA, Sylvia Fleis. Urban Society, 6th Ed. New York: Crowell, 1974.

GLICK, Isaac N. "An Analysis of the Human Resources Development Authority in Alberta." M.A. Thesis, University of Alberta, 1972.

GOLDEN, Earl. "Help Unlimited: The Practicality of a Neighbourhood Comprehensive Health Care Clinic for the City of Edmonton." Edmonton: University of Alberta, 1971.

GORDON, Jeoffry B. "The Politics of Community Medicine Projects: A Conflict Analysis." Medical Care 7, no. 6 (1969): 419-428.

GOULET, Denis. "'Development' . . . or Liberation?" International Development Review 13, no. 3 (1971): 6-10.

________. The Cruel Choice: A New Concept in the Theory of Development. New York: Atheneum, 1973.

GREENHILL, Stanley, and MORRISON, R. Bruce. Family Planning in Alberta. 4 vols. Edmonton: Department of Community Medicine, University of Alberta, 1976.

HAGAN, Everett E. On the Theory of Social Change: How Economic Growth Begins. Homewood, Ill.: Dorsey Press, 1962.

HAGGSTROM, Warren C. "The Power of the Poor." In Mental Health of the Poor, pp. 205-223. Edited by Frank Riessman, Jerome Cohen and Arthur Pearl. New York: Free Press, 1964.

HESSLER, Richard M. "Citizen Participation, Social Organization, and Culture: A Neighborhood Health Centre for Chicanos." Human Organization 36, no. 2 (1977): 124-134.

HOWARD, Lawrence C. "Decentralization and Citizen Participation in Health Services." Public Administration Review 32 (special issue October 1972): 701-717.

ILLICH, Ivan. Limits to Medicine. Medical Nemesis: The Expropriation of Health. Toronto: McClelland & Stewart; London: Marion Boyars, 1976.

INGLEWOOD HEALTH CENTRE. "Inglewood Design Brief." (Calgary, 1973).

________. "Inglewood Health Centre." Calgary, May 1975.

INNER CITY FIELD WORKERS GROUP. "Health Service Delivery in McCauley, Boyle Street, and Riverdale Communities." Memorandum by Alice Hanson, Juliann Hutcheon and David Gilbert, 26 September, 1975.

JELLARD, Janet. "Community Geriatrics in Edmonton." Internal Report, Edmonton Local Board of Health, 1975.

KANE, Robert L.; KASTELER, Josephine M.; and GRAY, Robert M. (eds.). *The Health Gap*: *Medical Services and the Poor*. New York: Springer, 1976.

KENDALL, Patricia L., and READER, George G. "Contributions of Sociology to Medicine." In *Handbook of Medical Sociology*. 2nd Ed. pp. 1-29. Edited by Howard E. Freeman, Sol Levine and Leo G. Reeder. Englewood Cliffs, N.J.: Prentice-Hall, 1972.

KOHN, Robert. *The Health of the Canadian People*. Royal Commission on Health Services. Ottawa: Q.P., 1967.

KOHN, Robert, and WHITE, Kerr L. (eds.). *Health Care*: *An International Study*. *Report of the World Health Organization/International Collaborative Study of Medical Care Utilization*. London: O.U.P., 1976.

KUPFER, George. *Edmonton Study*: *Community Opportunity Assessment*. Edmonton: Government of Alberta, Human Resources Research and Development, 1967.

KURTZ, Richard A.; CHALFANT, H. Paul; and KAPLAN, Kipton. "Inner City Residents and Health Decision-Makers: Perceptions of Health Problems and Solutions." *American Journal of Public Health* 64, no. 6 (1974): 612-613.

LALONDE, Marc. *A New Perspective on the Health of Canadians*: *A Working Document*. Ottawa: [Government of Canada], 1974.

LEFCOWITZ, Myron J. "Poverty and Health: A Re-Examination." *Inquiry* 10, no. 1 (1973): 3-13.

LEININGER, Madeleine. "Humanism, Health, and Cultural Values." In *Health Care Issues*, pp. 37-60. Edited by Madeleine Leininger and Gary Buck. Philadelphia: F. A. Davis, 1974.

LE RICHE, W. Harding, and MILNER, Joan. *Epidemiology as Medical Ecology*. Edinburgh: Churchill Livingstone, 1971.

MARGOLIS, Richard J. "Why 117 Medical Schools Can't Be Right." *Change*, October 1977, p. 26.

MECHANIC, David. *Medical Sociology*: *A Selective View*. New York: The Free Press, 1968.

MICHAEL, Mary Lee, and REID, Jim. "Operation Friendship Service and Research Project On Elderly High Risk Group. Project Number 1216-8-34. Final Report." [Edmonton 1976].

MILLIGAN, Geoffrey E. "Transient Men and Skid Row: An Analysis of Social Agency Programs in Edmonton, Alberta." M.A. Thesis, University of Alberta, 1971.

MOYNIHAN, Daniel P. *Maximum Feasible Misunderstanding*: *Community Action in the War on Poverty*. New York: The Free Press (paperback ed.), 1970.

McCLELLAND, David C. *The Achieving Society*. Princeton, N.J.: Van Nostrand, 1961.

McDONALD, D. N.; GREENHILL, Stanley; and LAING, Lory. *Community Health Resources for the Inner City of Edmonton*. Edmonton, Alberta: University of Alberta, Department of Community Medicine, 1977.

NADER, George A. *Cities of Canada*. Vol. 2: *Profiles of Fifteen Metropolitan Centres*. [Toronto]: Macmillan of Canada, 1976.

NAGLER, Mark. *Indians in the City*: *A Study of the Urbanization of Indians in Toronto*. Canadian Research Centre for Anthropology. Ottawa: Saint Paul University, 1970.

NIX, Harold J. *The Community and Its Involvement in the Study Planning Action Process*. Atlanta, Georgia: U.S. Dept. of Health, Education, and Welfare, Public Health Service, Centre for Disease Control, 1977.

NORMAN, John C. (ed.). *Medicine in the Ghetto*. New York: Appleton-Century-Crofts, 1969.

O'BYRNE, Michael B. "An Enquiry by a Commission . . . to investigate the services to single transient men in the City of Edmonton, the methods of providing such services and to assess allegations of mistreatment." April 1970.

PARNELL, E. D. Ted. *Stadium Impact*: *Anticipated Social Consequences of the Proposed Clarke Stadium Within the Context of Area Development*. Commissioned by Action Edmonton. Edmonton, February 1975.

________. *Disposable Native*. Edmonton: Alberta Human Rights and Civil Liberties Association, 1976.

RAMEY, Irene G. "The Crisis in Health Care: Fact or Fiction?" In *Health Care Issues*, pp. 17-27. Edited by Madeleine Leininger and Gary Buck. Philadelphia: F. A. Davis, 1974.

RASER, John. "Predictions and Proposals." In *Social Work in Australia*: *Responses to a Changing Context*, pp. 259-264. Edited by Philip J. Boas and Jim Crawley. Melbourne: Australia International Press & Publications, 1976.

RIESSMAN, Frank; COHEN, Jerome; and PEARL, Arthur, (eds.). *Mental Health of the Poor*. New York: The Free Press, 1964.

ROSEN, George. *From Medical Police to Social Medicine*: *Essays on the History of Health Care*. New York: Science History Publications, 1974.

ROSTOW, W. W. The Stages of Economic Growth: A Non-Communist Manifesto. New York: Cambridge University Press, 1960.

ROTHMAN, Jack. "Three Models of Community Organization Practice." In Social Work Practice, 1968, pp. 16-47. National Conference on Social Welfare. New York: Columbia University Press, 1968.

SEBRING, Robert H. "The Health Council as a Strategy for Community Change." Journal of the Community Development Society 8, no. 1 (1977): 74-85.

SEELEY, John R. "The Slum: Its Nature, Use and Users." In Internal Structure of the City: Readings On Space and Environment, pp. 464-474. Edited by Larry S. Bourne. New York: O.U.P., 1971.

SEERS, Dudley. "The Meaning of Development." Agricultural Development Council Reprint. New York: Agricultural Development Council, 1970.

________. "The New Meaning of Development." International Development Review 19, no. 3 (1977): 2-7.

SIDEL, Victor W. "Can More Physicians be Attracted to Ghetto Practice?" In Medicine in the Ghetto, pp. 171-180. Edited by John C. Norman. New York: Appleton-Century-Crofts, 1969.

SILVER, George A. "What Has Been Learned About the Delivery of Health Care Services to the Ghetto?" In Medicine in the Ghetto, pp. 65-72. Edited by John C. Norman. New York: Appleton-Century-Crofts, 1969.

SIMMONS, Helen; STINSON, Shirley M.; and HAZLETT, Clarke B. Evaluation of the Boyle Street Community Services Centre. January-November 1973.

SIMMONS, Helen. Final Evaluation of the Boyle Street Community Services Centre. January-December 1974.

SIMMS, Andrew C. L. The Craig Report. Edmonton: Alberta Human Rights and Civil Liberties Association, 1973.

SKINNER, Barbara J. et al. "Factors Affecting the Choice of Hospital-Based Ambulatory Care by the Urban Poor." American Journal of Public Health 67, no. 5 (1977): 439-445.

SNIDER, Earle L. Medical Services Research Report: Health Care and the Non-Institutionalized Senior Citizen in Edmonton. Edmonton: University of Alberta, 1973.

SPARER, Gerald, and JOHNSON, J. "Evaluation of OEO Neighbourhood Health Centers." American Journal of Public Health 61 (1971): 931-942.

STALKER, Peter. "Doctoring Evidence." New Internationalist, April 1977, pp. 4-6.

STRAUSS, Anselm L. Images of the American City. New York: Free Press of Glencoe, 1961.

STROMBERG, Jerome. "Community Involvement in Solving Local Health Problems in Ghana." Inquiry 10, (no. 2, Supplement June 1975): 148-155.

SUTTLES, Gerald D. The Social Order of the Slum: Ethnicity and Territory in the Inner City. Chicago: University of Chicago Press, 1968.

TIME-LIFE BOOKS. The Community. New York: Time-Life Books, 1976.

TOFFLER, Alvin. Future Shock. New York: Random House, 1970.

UNITED NATIONS CHILDREN'S FUND. A Strategy for Basic Services. New York: UNICEF, [1976].

UNITED NATIONS, Department of Economic and Social Affairs. Popular Participation in Development: Emerging Trends in Community Development. ST/SOA/106, Sales No. E.71.IV.2. New York: United Nations, 1971.

________. Popular Participation in Decision Making for Development. ST/ESA/31, Sales No. E.75.IV.10. New York: United Nations, 1975.

________. Innovative Approaches to Popular Participation in Development: An Annotated Bibliography. ESA/SDHA/Misc. 18. [New York: United Nations], October 1976.

UNITED STATES, Department of Health, Education, and Welfare, Public Health Service, Health Resources Administration. Use of Selected Medical Procedures Associated With Preventive Care, United States - 1973. Data from the National Health Survey, Series 10, Number 110. DHEW Publication No. (HRA) 77-1538. March 1977.

VALDIVIA DOMINGUEZ, Adolfo. "Stimulating Community Involvement Through Mass Organizations in Cuba: The Women's Role." International Journal of Health Education 20, no. 1 (1977): 57-60.

VYVERE, Barbara Van de; HUGHES, Mary; and FISH, David G. "The Elderly Chronic Alcoholic: A Practical Approach." Canadian Welfare 52, no. 4 (1976): 9-13.

WALLACE, Samuel E. Skid Row as a Way of Life. Totowa, N.J.: Bedminster Press, 1965.

WANG, Virginia Li. "Social Goals, Health Policy and the Dynamics of Development as Bases for Health Education." International Journal of Health Education 10, no. 1 (1977): 13-18.

WARREN, Roland L. Truth, Love, and Social Change, and other essays on Community Change. Chicago: Rand McNally, 1971.

WARREN, Roland L. The Community in America. 2nd ed. Chicago: Rand McNally, 1972.

WASHNIS, George J. Community Development Strategies: Case Studies of Major Model Cities. New York: Praeger, 1974.

WISEMAN, Jacqueline P. Stations of the Lost: The Treatment of Skid Row Alcoholics. Englewood Cliffs, N.J.: Prentice-Hall, 1970.

WORLD HEALTH ORGANIZATION. Alternative Approaches to Meeting Basic Health Needs in Developing Countries. A joint UNICEF/WHO study. Edited by V. Djukanovic and E. P. Mach. Geneva: WHO, 1975.

________. Health By The People. Edited by Kenneth W. Newell. 1975.

YOUNG, A. Joy. "Nursing Services - Single Men's Hostels - Edmonton and Calgary." Internal Report, Alberta Department of Health and Social Development. 26 June, 1975.

ZASOWSKA, M. Aloise Ann. "The Philosophical Index of Health Care Delivery in Our Culture." In Health Care Issues, pp. 1-16. Edited by Madeleine Leininger and Gary Buck. Philadelphia: F. A. Davis, 1974.

APPENDIX

AGENCIES SERVING EDMONTON'S INNER CITY

1. Agencies Located In The Area

1.1 Health

Dr. J. D. Craig

Harbour Light Centre and Rehabilitation Unit (Salvation Army)

Single Men's Hostel (Clinic) (A.S.S. & C.H.) (plus private physicians, the Avord Arms Clinic and the city's Health and Social Services Departments in the downtown commercial district)

1.2 Other Than Health

Alex Taylor Elementary School

Bissell Centre

Boyle Street Community Services Co-operative Ltd.

Chimo Youth Retreat Centre

Grierson Centre

Hope Mission

Humans on Welfare

Marian Centre

McCauley Boys and Girls Club

McCauley Senior Citizens Centre (Operation Friendship)

Men's Shelter

Operation Friendship

Sacred Heart Church

Sacred Heart Community School

Salvation Army
  Family Service Department
  Men's Social Service Centre
  Suicide Prevention Bureau
  Thrift Store

Single Men's Hostel (S.S. & C.H.)

St. Vincent de Paul Store

Student Legal Service of Edmonton

Th' House (United Church)

Women's Emergency Accommodation Centre

2. Agencies Located Outside The Study Area but staff work in the area

2.1 Health

Edmonton Community Service Program
  (A.A.D.A.C.)
    Community Worker

Edmonton Home Care Program
    Social Worker
    R.N.

Local Board of Health
    Public Health Nurses
    Geriatric Charge Nurse

Regional Community Mental Health Clinic
  (A.S.S. & C.H., Div. of Mental Health)
    Mental Health Nurse

Victorian Order of Nurses

2.2 Other Than Health

Edmonton Social Services
  Social Workers
  Community Worker

Meals-on-Wheels

North Edmonton Regional Office (A.S.S. & C.H.)

Police Department

3. Other Health Resources

Charles Camsell Hospital

Division of Social Hygiene (A.S.S. & C.H.)

Royal Alexandra Hospital

University of Alberta Hospital

U.A.H. Family Clinic

Norwood (Geriatric) Day Hospital

Local Board of Health
  Baby Clinic - Avord Arms
  Pre-natal Classes
  Birth Control
  Family Counselling Services

Intoxication Recovery Centre (A.A.D.A.C.)